

**RECORDS RELEASE AUTHORIZATION**

TO: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I authorize release of my medical records from \_\_\_\_\_ to  
(Date)

\_\_\_\_\_ to: Dr. Richard C. Ranard  
(Date) Dr. Lucy S. Beck  
3020 Hamaker Court, Suite 102  
Fairfax, VA 22031  
Fax: (703) 876-0253

\_\_\_\_\_  
Patient's Name (Please Print)

\_\_\_\_\_  
(Date of Birth)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Social Security Number)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Phone Number)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

**THANK YOU FOR YOUR PROMPT RESPONSE TO THIS REQUEST**