RECORDS RELEASE INFORMATION

To:

_____

Name

_____

Street

_____

City State Zip Code

I hereby authorize and request you to release to

☐ *Northern Virginia Center for Eye Care*

☐ 8150 Leesburg Pike, #909, Vienna, VA 22182 Ph: (703) 790-1780 Fax: (703) 734-0491
☐ 3020 Hamaker Ct., #503, Fairfax, VA 22031 Ph: (703) 698-2020 Fax: (703) 698-7043

☐ *Other (Physician, School, Attorney, etc.)*

_____

Name

_____

Street

_____

City State Zip Code

* *

Patient Phone: _____

Name: _____ Date of Birth: _____

Address: _____
Street City, State, Zip Code

Signature: _____ Date: _____
If not patient, state relationship

Witness to Signature: _____ Date: _____

☐ Mail to doctor ☐ Mail to patient ☐ Patient to pick up

There is a $15.00 processing fee ☐ Yes* ☐ No

*Payment is due at time of request. Release is only valid for thirty (30) days. If additional copies are desired after that period of time there will be another $15.00