RECORD 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, suite 909, Vienna, VA 22182 Ph: (703) 790-1780 Fax: (703) 734- 0491
3020 Hamaker Ct, suite 503, Fairfax, VA 22031 Ph: (703) 689-2020 Fax:(703) 698- 7043

Other (Physician, school, attorney, etc.)

____

NAME

____

Street

____

City State Zip Code

****

Patient information

Phone: ______________________

Name:____ Date of birth: ____________

Address:____

Street City, State, Zip code

Signature:____ Date:_____________

If not patient, state relationship-

Witness to signature:____ Date:_____________

__ Mail/Fax to doctor __ Mail to patient __ Patient Pick Up

There is a $25.00 processing Fee for the first 10 pages (Additional pages .15 each)

*Payment is due at time of request. Request is only valid for (30) days. If Additional copies are desire after that period there will be another $25.00 charge.