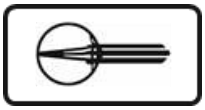
Tysons Corner

8150 Leesburg Pike
Suite 909
Vienna, Virginia 22182
Phone: (703) 790-1780
Fax: (703) 734-0491

MEDICAL RECORD RELEASE FORM

Northern Virginia Center for Eye Care



Fairfax/Merrifield

3020 Hamaker Court
Suite 503
Fairfax, Virginia 22031
Phone: (703) 698-2020
Fax: (703) 698-7043

Patient Name: _____ Date of Birth: _____

Address: _____ _____ _____ _____
Street City State Zip Code

E-Mail: _____ Phone: _____

I, _____, hereby authorize the release of my medical records as follows:
Patient or Guarantor Name

SEND RECORDS FROM:

☐ Northern Virginia Center for Eye Care

OR

☐ Doctor: _____

Phone Number: _____ Fax Number: _____

Address: _____ _____ _____ _____
Street City State Zip Code

SEND RECORDS TO: Physician, School, Attorney, Etc.

Addressee: _____

Phone Number: _____ Fax Number: _____

Address: _____ _____ _____ _____
Street City State Zip Code

OR

Northern Virginia Center for Eye Care: ☐ Tysons Office ☐ Fairfax Office

METHOD OF DELIVERY:

☐ Mail / Fax to Doctor ☐ Mail to Patient ☐ Patient Pick Up

Signature: _____ **Relationship to Patient:** _____ **Date:**_____

*Fees may apply. Payment is due at time of request. Request is only valid for (30) days.
If additional copies are desired after that period, there may be added charges.