ACCESS EYE

STAY FOCUSED

Arash Mansouri, *M.D.*
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Tracy Dzibela, *O.D.*
Joseph Dzibela, *O.D.*
Steffani A. Deas, *O.D.*,

Patient Records Release Form

Patient Name:

Patient Date of Birth:

O I authorize the following office to release my records to Access Eye Centers, P.C.

Name:

Address:

Phone: Fax:

O I authorize Access Eye Centers, P.C. to release my records to the following office/individual:
Name:

Address:

Phone: Fax:

Pursuant to Virginia code § 8.01-413, a fee of $20 will be charged for search and handling and $0.37 per page, and all postage and shipping costs. We will provide the records for the last three visits with our practice unless additional visits records are requested.

Patient/Guardian Printed Name:

Patient/Guardian Signature: Date: