

Patient Records Release Form

Patient Name:

Patient Date of Birth:

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

Name:

Address:

Phone:

Fax:



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:

FAX : 540-373-0141

WEB : ACESSEYE.COM

ROUTE 1

110 CAMBRIDGE STREET
FREDERICKSBURG, VA
22405

ROUTE 3

4516 PLANK ROAD
FREDERICKSBURG, VA
22407

PARKWAY

4701 SPOTSYLVANIA PARKWAY
SUITE 110
FREDERICKSBURG, VA
22408

AQUIA PARK

2761 JEFFERSON DAVIS HWY.
SUITE 205
STAFFORD, VA
22554

KING GEORGE

7961 KINGS HIGHWAY
KING GEORGE, VA
22485