ACCESS EYE
STAY FOCUSED

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Patient Records Release Form

Patient Name: _____

Patient Date of Birth: _____

☐ I authorize the following office to release my records to Access Eye:

Name: _____

Address: _____

_____

_____

Phone: _____ Fax: _____

☐ I authorize Access Eye 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.

By typing your name electronically on this form you are agreeing that your electronic signature is the legal equivalent of your manual signature.

Patient/Guardian Signature: _____ Date: _____

☐ Check here for the visually impaired patient, or a patient who has just received drops. I acknowledge that this form was read aloud to me. Read by: