



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:

PHONE: 540-371-2020

FAX: 540-373-0141

WEB: ACCESSEYE.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