Eye Specialists & Surgeons
OF NORTHERN VIRGINIA

Authorization for Release of Medical and/or Ophthalmic Records

Please complete the following information:

Patient's Name_____ Date of Birth_____

Address_____

City, State, Zip_____

I understand that a per page copy fee may apply for releasing medical records.

I request and authorize _____ to

release all Medical and/or Ophthalmic records of the patient named above to:

To: **Eye Specialists & Surgeons of Northern Virginia**
399 Fair Ridge Dr Suite 105
Fairfax VA 22033
Phone: 571-349-2191
FAX: 571-349-2211

OR:

To: _____
_____
_____
_____
_____

This request and authorization includes, but is not limited to:

- All examination and progress notes, including prescribed medications.
- All current and previous glasses and contact lens specifications.
- Any diagnosis, treatment, prognosis, recommendation and other pertinent data.
- Other (specify) _____

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

_____ _____ _____
Signature Date Print Name

IF INDIVIDUAL IS UNABLE TO SIGN THIS AUTHORIZATION, PLEASE COMPLETE THE INFORMATION BELOW

_____ _____ _____
Name of Guardian/Representative Legal Relationship Date

NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.