



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 3903 Fair Ridge Dr Suite 209 Fairfax VA 22033 Phone: 571-349-2191 FAX: 571-349-2211	To: _____ OR: _____ _____ _____
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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
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IF INDIVIDUAL IS UNABLE TO SIGN THIS AUTHORIZATION, PLEASE COMPLETE THE INFORMATION BELOW

_____ Name of Guardian/Representative	_____ Legal Relationship	_____ Date
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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.