VIRGINIA EYE CENTER, P.C.

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Authorization to Release Medical Records

PATIENT NAME:_____ **DATE OF BIRTH**:_____

This authorizes _____ to provide a copy, summary or narrative of my medical records as indicated by checkmark(s) below, or otherwise release confidential information.

- ❒ Complete Record
- ❒ Records of Care from the following dates:_____ to _____
- ❒ Records concerning the following conditions:_____
- ☐ Other, please specify:_____
- ☐ Confer with person(s) listed below orally about my medical information

The reason or purpose for this release of information is as follows:

- ❒ Referral to another physician
- ❒ For my own personal records
- ❒ For legal reasons
- ❒ For my primary care physician
- ❒ For transfer of care
- ❒ Other_____

Release medical records to the following person(s):

NAME: _____

ADDRESS AND/OR FAX:_____

_____

- I understand that by signing this form that I am authorizing the release of my medical information. I understand that Virginia state law requires this information to be provided within 15 days from the receipt of request and that a fee for preparing and furnishing this information may be charged according to the rulings set forth by the Virginia Statutory Code. Virginia Eye Center charges a $10.00 administrative fee, $.50 per page for the first 50 pages, $.25 for each page after 50, and postage, if applicable. I agree to be responsible for and pay the fee for providing copies of my medical information.
- I understand that I may revoke this authorization in writing at any time. Revoking this authorization will not affect uses or disclosures of my confidential information that occurred prior to revoking. I understand that confidential information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal or state law.
- If applicable, I understand that records may include information regarding sexually transmitted disease and/or HIV/AIDS status.

Patient Signature or Representative of Patient: _____

Relationship to Patient (Self, Guardian, Power of Attorney):_____ Date_____

Expiration: This authorization will expire 6 months from the date of signature or as otherwise indicated.

Please note that according to Virginia State law, we are only required to maintain patient medical records for six years from the last patient encounter with a few exceptions as indicated on our website.