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.

*Please note that we can provide access to your *records through your patient portal at no cost.

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

Patient/Guardian Signature:

Date:

*Some exclusions may apply based on dates of services or type of services.