Office Use Only Initials _____

Records Release Date _____
Via _____Mail, Fax, Other
Fees N/A or $_____

RICHMOND EYE ASSOCIATES, P.C.

Phone (804) 270-0330

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Information

Full Name: _____ Date of Birth: _____/_____/_____

Address: _____ Phone: _____

City, State, Zip _____ Richmond Eye Doctor _____

Authorization and Release

I request and authorize release of my medical records **FROM** Richmond Eye Associates, P.C., 4600 Cox Road, Suite 120, Glen Allen, VA 23060, **Phone:**(804) 270-0330, **Fax:**(804) 270-1003, and

TO (Physician or Entity): _____

Address: _____

City, State, Zip _____

Phone: _____ Fax: _____

Additional information or specific office visit records requested: _____

I understand that I have the right to access my medical records in accordance with law and policies of Richmond Eye Associates. I hereby authorize the disclosure of my protected health information (or that of an unemancipated child for whom I have legal authority) as described above. I understand (1) this authorization is a one-time authorization only in effect until the records are forwarded, (2) this authorization is voluntary and my treatment will not be coordinated on signing this authorization, (3) I have the right to revoke this authorization, (4) Richmond Eye has the right to deny me access to my records in certain circumstances in accordance with law, and (5) any information released may be subject to redisclosure by the recipient and may no longer be protected by applicable law.

I understand that I will be charged, and will pay, cost-based fees of: a $10.00 administrative fee and $0.50 per page for the first 50 pages and $0.25 per page after 50 pages, plus all postage costs, for personal copies of medical records, as well as requests for law firms, disability determination cases, and other special circumstances. Records forwarded directly to a physician's office will not result in fees.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Name of Legal Representative (if different from patient) Relationship of Legal Representative to Patient (Attach legal documentation of authority)