Northern Virginia Ophthalmology Associates, P.C.

Medical Records Request

Patient Name:
Patient ID:
Date of Birth:
Address:
Phone:
Email:

RECORDS REQUESTED FROM (please include name, address, and or fax number if applicable):

[ ] Northern Virginia Ophthalmology Associates, P.C.

-TO-

[ ] _____
_____
_____

RECORDS TO USE OR DISCLOSE FROM (please include name, address, and or fax number if applicable):

[ ] _____
_____
_____

-TO-

[ ] Northern Virginia Opthalmology Associates, P.C.

Payment: There is a $15.00 fee for the release of records for personal use. For OCTs and Fundus Photos, there is an additional $10.00 fee. There is no fee if the records are being released to another medical practice. Applicable payments may be made via credit card, check, or cash. We accept Visa, MasterCard, and Discover.

Charge: _____

Requesting Party Name (Printed): _____

Relationship to Patient: _____

Signature: _____

Date: _____

Medical Records Office:

Falls Church: 6565 Arlington Boulevard, Suite 250, Falls Church, VA 22042
Phone: (703) 534-3900 - Option #9 for Medical Records| Fax: (703) 536-2720

Email: medicalrecords@nvoaeyes.com