

Medical Records Request

Patient Name:

Patient ID:

Date of Birth:

Address:

Phone:

Email:

INFORMATION REQUESTED FROM (WHERE YOUR CURRENT RECORDS ARE): *(Name of practice or provider)*

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone #: (____) _____ Fax #: (____) _____ Email: _____

SEND INFORMATION TO (WHERE RECORDS WILL GO): *(Name of practice or provider)*

Name: _____ Send by: Mail Fax Secure Email

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: (____) _____ Fax: (____) _____ Email: _____

Payment: There is a \$25.00 fee for the release of records for personal use. For printed 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.

Total charge: _____

RECORDS REQUEST MAY TAKE UP TO 10 BUSINESS DAYS FROM THE DATE THAT WE RECEIVED THIS REQUEST

I, _____ *(Patient name)*, hereby grant permission for you to release confidential health information about me, by releasing a copy of my medical record, or a summary or narrative of my protected health information, to the physician/ person/ facility/ entity.

Patient/Guarantor name (Printed): _____ **Signature:** _____

IF NOT PATIENT:

Requesting Party Name (Printed): _____ **Relationship to Patient:** _____

Signature: _____ **Date:** _____

Medical Records Office:

Falls Church: 6565 Arlington Blvd, Suite 250 Falls Church, VA 22044

Phone: (703) 534-3900 - Option #9 for Medical Records

Fax: 703-536-3729

Email: medicalrecords@nvoaeyes.com