Northern Virginia Ophthalmology Associates, P.C.

RECORDS RELEASE REQUEST

Patient Name: _____ Date of Birth: _____

Address: _____

I, _____, hereby authorize the release of my medical records as follows:
(Patient's name or Guarantor)

1) SEND MY RECORDS FROM:

- ☐ Northern Virginia Ophthalmology Associates

  OR

- ☐ Dr. _____

  Phone: _____ Fax: _____

  Address: _____

2) SEND MY RECORDS TO:

- ☐ Dr. _____

  Phone: _____ Fax: _____

  Address: _____

  OR

Northern Virginia Ophthalmology Associates

- ☐ Falls Church – 6565 Arlington Boulevard, Suite 250, Falls Church, VA 22042
  Phone: 703-534-3900 Fax: 703-536-3729

- ☐ Fairfax – 3975 Fair Ridge Drive, Suite 100 S (South Lobby), Fairfax, VA 22033
  Phone: 703-620-2701 Fax: 703-620-5907

- ☐ Alexandria- 6363 Walker Lane, Suite 150, Alexandria, VA 22310
  Phone: 703-922-0906 Fax: 703-341-6981

Signature _____ _____
(Relationship to Patient)

There is a $15 processing fee for medical records and payment is due at the time of request. There is an additional $10 fee for copies of Fundus Photo's, Optical Coherence Tomography (OCT) and Topography's that is due at the time of request. Release is valid for thirty (30) days. If additional copies are desired after the 30 days, there will be an additional $15 charge.