Northern Virginia Ophthalmology Associates, P.C.

Medical Records Request

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

INFORMATION REQUESTED FROM: (*Name of **practice** or **provider***)

Name: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone #: (____)_____ Fax #: (____)_____ Email:_____

SEND INFORMATION TO: (*Name of **practice** or **provider***)

Name: _____ Send by: [_] Mail [_] Fax [_] Secure Email
Address: _____ City: _____ State: _____ Zip Code: _____
Phone: (____)_____ Fax: (____)_____ Email: _____

Payment: There is a $20.00 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