Arlington Eye Center

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize protected medical records and related information related to:

PATIENT NAME:_____

To be released to:

NEW PROVIDER NAME: _____

ADDRESS: _____

ADDRESS: _____

ADDRESS: _____

PHONE: _____ FAX: _____

Any restriction I wish to impose upon this authorization follows:

_____

_____

I understand that I may be charged for copies of my medical records and will be notified at the time of this request.

_____ _____

Signature for Release of Records Date

_____

Signature for parent and/or HCP

1635 N George Mason Blvd, Suite 100-Arlington VA 22205

*{703}-524-5777 ** FAX: (703) 908-9647*

EMAIL FORM COMPLETED (one per patient)

Arlingtonrecords@ceceye.com