PATIENT RECORDS RELEASE FORM

patient information:

PATIENT NAME: _____

PATIENT ADDRESS: _____

_____

DOB: _____

PHONE NUMBER: _____

request records from:

OFFICE NAME: _____

PROVIDER NAME: _____

OFFICE ADDRESS: _____

_____

OFFICE PHONE: _____

OFFICE FAX: _____

I HEARBY AUTHORIZE THE RELEASE OF ANY AND ALL MEDICAL RECORDS TO FAMILY VISION CARE OF RICHMOND AND MY PROVIDER AS INDICATED.

SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____

Family Vision Care of Richmond

OUR PROVIDERS:

DR. DAVID LEROUX

DR. PATRICIA DAYLOR

DR. TRACY POLING

DR. JEFF MICHAELS

DR. STEPHANIE MATSKO

DR. VERA DHAM

OPTOMETRISTS

CONTACT US

[p] 804.217.9883

[f] 804.217.9065

4114 Innslake Drive
Glen Allen, VA
23060