SOUTHSIDE EYE CARE
PROFESSIONAL EYE CARE & SURGERY

3206 Churchland Blvd.
Chesapeake, VA 23321
Phone: (757) 484-0101
Fax: (757) 484-0515

Authorization for Release of Information

[ ] SouthSide Eye Care is authorized to release Medical Records to:

OR

[ ] You are herby requested to furnish SouthSide Eye Care the **Records**, **Visual Fields, OCT's**, **Fundus Photos** and any **Surgical Notes**

Of:

Patients Name: _____

Patients SS#: _____-_____-_____ Patients DOB: _____/_____/_____

Patients Phone #: _____-_____-_____

TO: _____

_____

_____

The fee for records is $.50 per page with a max page charge of $15.00 plus an additional fee of $5.00 for postage if mailed.

Patients signature: _____ Date: _____/_____/_____

Reason for request:

[ ] Leaving the area
[ ] Transferring to another practice Reason: _____
[ ] Records to a specialist, PCP, or for second opinion
[ ] Insurance company request
[ ] Other: _____

Witness: _____ Date: _____/_____/_____