



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 hereby 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: _____ / _____ / _____