Virginia Eye Institute
BRINGING YOUR WORLD INTO FOCUS

400 Westhampton Station Building B
Richmond, Virginia 23226

Release of Medical Records Authorization

Patient Information: **VEI Doctor:** _____

Name of Patient _____ Date of Birth _____

Address _____

City, State, Zip _____ Phone_____

Physician or Office Authorized to Release Information:

FROM: Virginia Eye Institute, 400 Westhampton Station, Richmond VA 23226, Fax (804) 282-1967

TO: _____

Address _____

City, State, Zip _____

Phone: _____ Fax:_____

Dates of Service to be released: ALL _____ (The last 4 years will be released unless otherwise specified.)

Other: Please specify: _____

***Please supply the date of the upcoming appointment if applicable:** _____

Reason for Request: (Please circle one)

1. I have moved 2. VEI doesn't accept my insurance. My insurance is:_____
3. Poor experience at VEI 4. VEI Financial Policy 5. Other:_____

I hereby authorize the disclosure of my protected health information and medical information (or that of an un-emancipated minor child for whom I have legal authority) as described above. I understand 1)that this authorization is a one-time authorization and only in effect until the information is forwarded, 2) that this authorization is voluntary and that my treatment will not be conditioned on signing this document, 3) that I have the right to revoke this authorization or to inspect or copy the protected health information described in this document by sending written notification to the Privacy Officer at the address above, 4) that any information released may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State law.

****I understand that a $10 administrative fee as well as $0.50 per each of the first 50 pages and $0.25 for each subsequent page will be assessed for personal copies of records, as well as requests for law firms, disability determination cases, and other special circumstances. Records will be delayed until payment is received.** -**
Please note that requesting records be forwarded to another physician's office will not incur a fee.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of Personal Representative (If different from patient) Relationship
(***Attach Necessary Documentation***)