GRIFFEY EYE CARE & LASER CENTER

A US EYE COMPANY

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Information:

Name:		
Address:		
City:	State:	**Zip:**
Phone:	Date of Birth:	

Request Medical Information FROM: ☐ **GEC** ☐ **Other (fill in below)**

Physician/Practice Name:			
Address:			
City	State:	Zip:	Phone:

To be sent TO: Griffey Eye Care

☐ 560 Kempsville Road, Suite 100 Chesapeake, VA 23320

☐ 204 Carmichael Way #200 Chesapeake, VA 23322

☐ **OTHER**

Physician/Practice Name:		
Address:		
City:	State:	Zip:

☐ Complete medical records in your possession concerning my illness and/or treatment during the period from _____ to _____.

Reason(s) for Records Request:

☐ Moving out of area ☐ Copy for another physician ☐ Insurance change

☐ Primary physician needs records ☐ Change of provider ☐ Other (please explain)

I authorize the release of information including diagnosis, records, examination rendered to me, and claims information. This release of information will remain in effect until terminated by me in writing.

***Please allow up to 30 days for request to be processed*.**

Signature of Patient/Legal Representative **Date**

FOR OFFICE USE ONLY	
Release Records of Dr.	Approved by Dr.
Date:	Request Completed By: