Legacy Eye Care, LLC

Patient Release of Medical Records Form

Patient's Name: _____ request and give my permission to release my Medical

Records for the time period dating from_____ to _____from the following

Legacy Eye Care Locations: (Please circle which location)

3500 South Crater Road **315 Furr St.**

Petersburg, VA 23805 **South Hill, VA 23970**

Please indicate where the Medical Records as listed above are to be released to:

Self: _____ Doctor's office: _____Other: _____

Please circle method of release: Mail Fax Pick up

Name: _____

Address: _____

City: _____State: _____Zip: _____

Phone Number: _____

Fax Number: _____

Comments: _____

If faxing or mailing the Release of Medical Records Form to the Legacy Eye Care, include a copy of a photo ID such as a State issued Driver's License, State Issued ID Card, or Passport.

Type of ID Presented: _____ ID #_____

_____ _____ _____

Printed Patient Name **Date of Birth** **Social Security #**

_____ _____

Patient's Signature/ Patient's Guardian **Today's Date**

**** Please allow time for processing of release form. Medical records will be released within 1-3 days upon receipt of Medical Records Release Form. This form will be effective for 6 months from the date of signature. Please fax back release form to 804) 441-9514 or mail it into one of our locations listed above.**