

Legacy Eye Care, LLC.

Patient Medical Records Release Form

Patient's Name: _____ request and give my permission to release my medical records for the following dates span. From: _____ to _____.

Legacy Eye Care: (Please circle which location)

3500 South Crater Road 315 Furr St. 671 Southpark Blvd. 12000 Iron Bridge Rd

Petersburg, VA 23805 South Hill, VA 23970 Colonial Heights, VA 23834 Chester, VA 23831

501 Lombardy St

South Hill, VA 23970

Please indicate where the medical records listed above are to be released to:

Self: _____ **Doctor's office:** _____ **Other:** _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Fax Number: _____

Comments: _____

Please circle method of release: Mail Fax Pick up

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

Patient's Signature/ Patient's Guardian

Today's Date

**** Please allow time for processing of the release form. Medical records will be released within 1-3 days upon receipt of the Medical Records Release Form. This form will be effective for 12 months from the date of signature. Please fax the release form back to 804) 441-9514 or mail it in Thank you!**