Authorization to Release Healthcare Information

Patient Name: _____ **Date of Birth:** _____

I request and authorize:

Physician/Practice: _____

Phone Number: _____ Fax Number: _____

To release the following healthcare information of the patient named above:

☐ Complete copy of medical record
☐ Disclosure log
☐ Specific Information: _____

To:

Retina Institute of Virginia, PLLC
Ali R. Tabassian, M.D., Ph.D. ~ Juan A. Astruc, Jr., M.D.
J. Stewart O'Keefe, M.D. ~ Bryan J. Schwent, M.D.

☐ 8720 Stony Point Parkway, Suite 105, Richmond, VA 23235
Phone: 804-644-7478 Fax: 804-644-8224
☐ 1671 Jefferson Davis Highway, Suite 103, Fredericksburg, VA 22401
Phone: 540-368-5230 Fax: 540-368-5233
☐ 5408 Discovery Park Boulevard, Suite 100, Williamsburg, VA 23188
Phone: 757-345-3510 Fax: 757-345-3563

I understand that I have the right to access my medical records in accordance with the law and the policies of the Medical Practice. I understand that the Medical Practice may charge me for copies of my medical records, and I have been provided a fee schedule.

I understand that the Medical Practice has the right to deny me access to my records in certain circumstances in accordance with the law. If the Medical Practice denies me access to my medical information, I understand it will provide me with the reason for the denial in writing and describe whether I have a review of the denial performed by a licensed health care professional.

Please note that information disclosed pursuant to this request is no longer under the control of the Medical Practice and may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Signature of Patient_____ **Date**_____

Patient Representative_____ **Date**_____

Relationship to Patient_____

This request for medical records will expire one year from signature date.