



BEACH EYE CARE

www.beacheyecare.com

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RECORDS REQUEST

Please note that if records contain color images, please mail!

Date: _____

To: _____
(Doctor's name or name of practice)

Fax: _____
(If you do not know fax #, please put phone number)

I hereby authorize you to release my medical records to:

**Beach Eye Care
1201 First Colonial Road
Virginia Beach, VA 23454
Fax: (757) 412-2606**

Thank you for your assistance.

Patient's Signature: _____

Patient's Name (Print): _____

Patient's Date of Birth: _____

Witness: _____