BEACH EYE CARE

BeachEyeCare.com | 757.425.5550

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Records Release Authorization

*Medical Records WILL be in a compressed digital format unless requested otherwise. Color Imaging available in this format only, NOT available via Fax.

Account number: _____ Beach Eye Care Provider: Select Provider _____

I,_____, _____ **am requesting the release of –**
Print Patient Name Date of Birth

☐ **Entire Chart** (processing up to 30 days) ☐ **Last office notes** ☐ **Imaging Only** ☐ **Specific dates of service**

Please send my Medical Records

To the attention of: _____

At the address of: _____

I would like a copy made available to me via:

☐ **Pick-up @ FC, GB, HR, KV, or RM** ☐ **Mail** ☐ **Fax to:** _____

For the purpose of:

☐ **Second Opinion** ☐ **Moving/Moved out of area** ☐ **Changing Physicians** ☐ **Other:** _____

_____ _____
Patient / Guardian Signature Date

Your typed name constitutes a digital signature

If you do not anticipate on returning to our practice, please indicate whether it was a result of circumstances we can mitigate going forward:

☐ Wait times too long ☐ Scheduling difficulties ☐ Billing problems ☐ Dissatisfaction with medical care
☐ Discourteous staff member ☐ Other (please describe): _____