Arlington Eye Center

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____

Date of Birth: _____ Home Zip Code: _____

Please provide the information where records are to be sent, and method:

New Practice / Provider Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax Number: _____

If they electronically receive records, please provide email: _____

Please detail if the entire clinical record for our provider is to be released, or a specific date/visits:

_____

Allow 2-3 weeks for the records to be sent, if there is an emergency we can quickly send the last visit note – call our office : (703) 524-5777

If you are below the age of 18, please ensure the guardian signs below.

_____ _____
Signature of Patient Date

_____ _____
Signature of Legal Guardian Date

This is authorizing the submission of protected health information, and may only be completed by the patient (or legal guardian).

You may fax to: (703) 908-9647
Or email: Arlingtonrecords@ceceye.com