# Release of Medical Records to Dominion Eye Care, P.C.

8140 Ashton Ave. Suite 120
Manassas, VA 20109
Phone: 703-361-3128
Fax: 703-361-3670

DOMINION EYE CARE

388 Hospital Drive
Warrenton, VA 20186
Phone: 540-349-0906
Fax: 540-349-0298

Patient Name _____ Date of Birth _____/_____/_____

SSN _____ Address _____

City _____ State _____ Zip Code _____

Preferred Contact Phone Number _____

**Information Requested From**

Name of Physician or Practice/Group _____

Address _____ City _____

State _____ Zip Code _____ Phone _____

Fax _____ Email (if applicable) _____

**Send Information To**

Name Dominion Eye Care, P.C. Send by ☐ Mail ☐ Fax

Address _____ City _____

State _____ Zip Code _____ Phone _____

Fax _____ Email (if applicable) _____

Treatment Dates From _____ to _____

Type of Records to be Released: ☐ All Records ☐ OCT ☐ Visual Fields ☐ Operative Reports ☐ Lab Reports ☐ GDX

I,_____, hereby give permission for you to release confidential health information about me, by releasing a copy of my medical record, as indicated by my choice(s) above, to the physician, practice/group named above.

Patient Signature _____ Date _____