SIEHT
A FALKENBERG EYE & LASER CENTER

12 Chatham Heights Rd. Ste 100, Fredericksburg, VA 22405
Phone 540-371-2777 Fax 540-371-0922

Authorization to Release Confidential Medical Records

I, _____ DOB _____ SS# _____

ADDRESS _____CITY _____

STATE _____ ZIP CODE _____ PHONE _____

☐ AUTHORIZE SIEHT, A FALKENBERG EYE & LASER CENTER TO RELEASE THE INFORMATION REQUESTED BELOW, IN ACCORDANCE WITH COMMONWEALTH AND SIEHT POLICIES TO THE PARTY BELOW.

☐ **OR** AUTHORIZE THE PARTY BELOW TO RELEASE SPECIFIED INFORMATION BELOW TO SIEHT- A FALKENBERG EYE & LASER CENTER.

NAME _____

ORGANIZATION _____

ADDRESS _____

_____

PHONE_____ FAX_____

INFORMATION TO BE RELEASED:

☐ Complete Chart ☐ EKG ☐ OCT ☐ Photos ☐ Op notes ☐ Physician's Progress Notes

☐ Corneal Topography ☐ Visual Fields ☐ Ascan ☐ IOL Information ☐ Other_____

For: ☐ continuing care ☐ Surgery ☐ Personal use ☐ Other _____

Virginia Law allows for copy charges as follows: $10 administrative fee plus $.50 per page for the first 50 pages and .25 per page thereafter.

I hereby authorize release of information as indicated above. No coercive measure induced me to sign this form. I release Sieht from any claim I have or may have in the future for the release of this information. I understand I may revoke this consent at any time, except where actions have already been taken. This authorization will expire in 6 months.

Patient Signature: _____ Date: _____

Parent/Guardian/POA Signature: _____ Date: _____

Witness Signature _____ Date: _____