Record Release Request to Receive Patient Records

COMMONWEALTH EYE CARE ASSOCIATES
3855 Gaskins Rd, Henrico, VA 23233

Phone (804) 217-6363 Fax (804) 217-6400

Patient Information:

Patient Name_____ Patient Date of Birth_____

Patient Address_____

Name & Address of Doctor Authorized to Release Information to CECA:

Doctor Name_____

Address_____

Phone_____ Fax _____

Notes: _____

Name & Address of Doctor to Receive Patient Information:

Commonwealth Eye Care Associates, 3855 Gaskins Rd, Henrico, VA 23233

Fax: 804-217-6400

Email: records@commonwealtheye.com

Description of Chart Information being Requested:

A Copy of my Medical Records, including Last Visual Fields and Other Testing, Past Eye Surgery Information,

Most Recent Chart Notes and

_____

Patient Signature_____Date_____

Please note your plans for ongoing care for your ophthalmic eye care needs:

_____ I Will be Continuing my care with Commonwealth Eye Care Associates

_____ I have a New Doctor and Will Not Be Returning to Commonwealth Eye Care for my care

The information contained in these records is privileged, confidential and intended only for the individual or entity named above.

If you not the intended recipient and receive these records in error, please notify us immediately by telephone. Thank you.