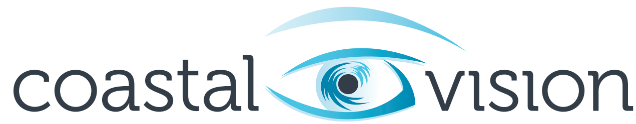

REQUEST FOR THE RELEASE OF PATIENT RECORDS

PATIENT NAME: ______________________________ DATE OF BIRTH: ______________

ADDRESS: ____

PHONE NUMBER: ______________________________ LAST VISIT: ______________

PRACTICE TO RELEASE RECORDS FROM: ____

ADDRESS: ____

PHONE: __________________________ FAX: ______________________________

TYPE OF RECORDS REQUESTED: ____

I, ______________________________, FORMALLY REQUEST YOU TO RELEASE MY RECORDS IMMEDIATELY TO COASTAL VISION SUCH THAT MY CARE MAY CONTINUE IN A TIMELY AND UNINTERRUPTED MANNER. I UNDERSTAND THAT I HAVE A RIGHT TO MAKE SUCH A REQUEST AND THAT SUCH A REQUEST WILL REQUIRE MY SIGNATURE AUTHORIZATION EACH AND EVERY TIME.

SIGNATURE: ______________________________________ DATE: ______________

PLEASE RELEASE RECORDS VIA FAX TO:

- ❑ **RED MILL OFFICE:** **(757) 426-2020, Option 1**
- ❑ **HARBOUR VIEW OFFICE:** **(757) 426-2020, Option 4**
- ❑ **VOLVO PARKWAY OFFICE:** **(757) 426-2020, Option 2**
- ❑ **SALEM CROSSING OFFICE:** **(757) 426-2020, Option 3**
- ❑ **OR VIA EMAIL:** **info@coastalvisionva.com**

Optometrists

Dr. Russell Beach
Dr. Jessica Lin Nilsson
Dr. Scott Nilsson
Dr. Abhner Wang
Dr. Arieneh Tahmasian

2077 Lynnhaven Pkwy • Virginia Beach, VA 23456
2033 Fisher Arch • Virginia Beach, VA 23456
2051 Sun Harbour Ave • Suffolk , VA 23435
1116 Volvo Pkwy • Chesapeake, VA 23320

www.coastalvisionva.com **757.426.2020**