WILLIAMSBURG
Eye Care
Drs. Lundberg & Lodwick, Optometrists

REQUEST FOR RELEASE OF RECORDS

Doctor: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax#:_____

I hereby request that all medical records documenting care that I have received in your office be forwarded to Williamsburg Eye Care. I acknowledge that Williamsburg Eye Care will become my primary eye care provider and I am waiving any privileges I may have to the confidentiality of this information and authorize you to release said information as soon as possible.

Thank you for your prompt attention to this request.

_____

Patient Name Date of Birth

_____

Patient Signature Date

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www.WilliamsburgEye.com