

# Records Release

To: Wagner Macula & Retina Center  
6160 Kempsville Circle, Suite 250B  
Norfolk, VA 23502  
Fax: 757-481-1285

I hereby authorize and request you release my medical records to:

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The complete medical records in your possession concerning my illness and/or treatment during the period from \_\_\_\_\_ to \_\_\_\_\_

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

SSN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Relationship to Patient