WAGNER
MACULA & RETINA CENTER
Saving Sight–Enhancing Lives

Records Release

To:

_____

_____

_____

_____

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

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

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