WAGNER
MACULA & RETINA CENTER
Saving Sight–Enhancing Lives

RECORDS RELEASE

To:

_____

_____

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

Wagner Macula & Retina Center
5520 Greenwich Rd., Suite 204
Virginia Beach, VA 23462
Fax: 757-481-1285

The complete medical records in your possesion 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