

RECORDS RELEASE

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

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

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