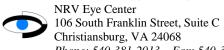
Tedd R. Puckett, M.D., FACS, ABES



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NRVeye.COM

Medical Retina Cataracts Glaucoma Pediatrics Oculoplastics

4/3/2021

CONSENT FOR RELEASE OF NRV EYE CENTER MEDICAL RECORDS

Patient Name:		SS#:	
DOB:	Patient Phone	e: (
Information to be re		ENTER PC TH FRANKLIN STREET NSBURG VA 24073	
Information to be re Office Name Mailing Add	eleased to: / Branch: ress:		
FAX #: (if mo	unless otherwise spec	will be mailed or sent by password protected ified)	d e-mail
	by Email, records will be encryp	oted in ZIP file with password same as last	
Scope of Records Re	equested: Last 2 exam	s Oldest Exam All Recor	ds ek processing)
Purpose of release:	No cost: Continuity of care Communication to Other Provider		
	Standard Processing Fee, inquing Legal Representation other than patient portal	ire at office 540-392-2013: Disability Claim Patient w Other:	ants copy
under state and federal l for by state and federal l understand I may revok	laws and cannot be re-disclosed law. A copy may be accepted by e this authorization at any time	stand that the information to be released I without my further written consent unlow the health care facility in lieu of the original, except to the extent that action has alrest one year from the date of signature.	ess provided nal. I
Signature of Patient	Date	Signature of Parent/Guardian/ Legal Representative	Date
Signature of Witness	Date	Relationship	Date
Office Use: Received Date: Appointments Missec	Payment Received Da	te: Records Sent Date:	