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NRV Eye Center
106 South Franklin Street, Suite C
Christiansburg, VA 24068
Phone: 540-381-2013 Fax: 540-381-8680 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: (_____) _____ - _____

Information to be released from: **NRV EYE CENTER PC**
106 C SOUTH FRANKLIN STREET
CHRISTIANSBURG VA 24073

Information to be released to:

Office Name / Branch: _____

Mailing Address: _____

_____

_____

FAX #: ***(if more than 20 pages, then records will be mailed or sent by password protected e-mail unless otherwise specified)***

(_____) _____ - _____

Email: ***(if sent by Email, records will be encrypted in ZIP file with password same as last 4 of SS#)***

_____ **@** _____

Scope of Records Requested: ☐ Last 2 exams ☐ Oldest Exam ☐ All Records
☐ Last VF/OCT ☐ Summary Letter *(add 1 week processing)*

Purpose of release:

No cost:
☐ **Continuity of care** ☐ **Communication to Other Provider**

Standard Processing Fee, inquire at office 540-392-2013:
☐ **Legal Representation other than patient portal** ☐ **Disability Claim** ☐ **Patient wants copy** ☐ **Other: _____**

I certify this authorization is made voluntarily, I understand that the information to be released is protected under state and federal laws and cannot be re-disclosed without my further written consent unless provided for by state and federal law. *A copy may be accepted by the health care facility in lieu of the original.* I understand I may revoke this authorization at any time, except to the extent that action has already been taken. If not previously revoked, this consent will expire one year from the date of signature.

_____	_____	_____	_____
Signature of Patient	Date	Signature of Parent/Guardian/ Legal Representative	Date
_____	_____	_____	_____
Signature of Witness	Date	Relationship	Date

Office Use:
Received Date: _____ Payment Received Date: _____ Records Sent Date: _____
Appointments Missed by Patient: _____

You can email this completed form to reception@nrveye.com