DRESSLER OPHTHALMOLOGY ASSOCIATES PLC

3930 Pender Dr. Suite 10
Fairfax, VA 22030
(P) 703-273-2398
(F) 703-273-0239

Linda B. Dressler, MD
Daniel Geller, MD
Jacqueline Fredrick, OD
Randall Wong, MD

RELEASE OF MEDICAL RECORDS FROM DRESSLER OPHTHALMOLOGY

As the person signing this consent, I understand that I am giving my permission to Dressler Ophthalmology Associates to disclose my confidential medical records to the specified entity. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the medical entity in possession of my medical records.

FEES FOR MEDICAL RECORDS TRANSFER ARE AS FOLLOWS:

$10 for searching, handling of medical records

$0.50/ page for copying the first fifty pages

$0.25/ page for copying additional pages beyond fifty pages

Any applicable postage if mailing is requested.

I understand I owe $ __________ for preparing and sending copies of my records and that this fee is to be paid prior to sending and preparing records. If an additional formal medical report is required, additional fees may apply.

DATE(S) OF INFORMATION TO BE DISCLOSED: From ________(month/year) to ________(month/year)

If left blank, only information from the past two (2) years will be disclosed

I would like to:

_____pick up my records in person, call (____) _____________ when ready

_____ have my records mailed to this address____

REASON FOR REQUEST: ❏ Personal ❏ Transfer of Care ❏ Disability ❏ Insurance ❏ Legal Review ❏ Continuing Care ❏ Other (please explain): __________________________

-I understand that I may revoke this authorization at any time, in writing.
-Unless otherwise noted, I understand this authorization WILL EXPIRE when ALL REQUESTED RECORDS have been transferred OR when a period of NINETY DAYS has transpired.
-**I understand that routine requests typically take 7-10 days to process**.
-I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulation, the information described above may be disclosed and would no longer be protected by these regulations.

Print Name:____D.O.B.__________________________

Patient Signature:_____________________________________ Date: __________________________

Doctor Review

LD_____

DG_____

JF_____

RW_____