Vision Specialists of Annapolis

116 Defense Hwy
Suite 502
Annapolis, MD 21401
Phone: 410-224-8908
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Record Release Form

Today's Date:________________

Patient Name:________________________ ____

Birth Date:_________________________ Phone Number:________________________________

Address:____

City,State,Zip:____

Patient/Guardians Signature:____

Print Name:________________________________ Date:__________________

By signing this form, I authorize Vision Specialists of Annapolis to release a copy of my medical records, a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

To:________________________

Address:____

City,State,Zip:____

Phone Number:________________________________ Fax:________________________________

Please check one: Mail Fax Pick up

Please check one: Entire Patient Records Last Exam/Office Visit:

If you are a patient requesting a copy of your own records, a processing fee of $0.76 per page will be applied. In addition, for requests from another healthcare provider, law firm or other third party, a processing fee of $22.88 will be applied. We will notify you of the total amount due upon receipt and processing. Requests will be processed within 14 business days of receipt of payment. Thank you.