NewView EYE CENTER
See what you've been missing®

Jacqueline D. Griffiths, M.D., P.C.

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MEDICAL RECORDS RELEASE

I, _____, hereby request that **Jacqueline D. Griffiths, M.D.,** provide copies of my medical records to:

_____, or submit to the same a report of my diagnoses, treatment and recommendations as well as other data pertinent to my eye care during the period from _____ to _____ **(the default period is 2 years)**.

REASON FOR RECORDS REQUEST:

- ☐ LEAVING PRACTICE – Reason: _____
- ☐ SECOND OPINION
- ☐ OTHER _____

As the person signing this consent, I understand that I am giving my permission to the above-named provider or other named third party for disclosure of confidential health care records. 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 person who is in possession of my records. A copy of this consent and a notation concerning the persons or agencies to which disclosure was made shall be included with my original records. The person who receives the records to which this consent pertains may not disclose them to anyone else without my separate written consent unless such recipient is a provider who makes a disclosure as permitted by law.

Due to increased demands for, and costs of paper work in a medical office, a fee of $25 is charged for preparation, copy, and transfer of the first 30 pages of any medical record. An additional fee of 50 cents per page will be charged for each additional page. **These fees are in accordance with Virginia law**.

The total charge for preparing these records is $_____.

Once payment is received, your records will be transferred within 14 business days.

I understand that I am responsible for this charge.

Signed _____ Date _____

Print name _____ Witness _____