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RECORDS RELEASE

Optometry
Board
Certified

Pediatric, Adult,
and Geriatric
Vision Care

Quality Eyewear

Contact Lenses

Eye Disease
Treatment

Glaucoma
Treatment

Dry Eye
Treatment

Eyelid Disorders

Low Vision

Diagnosis and
Consultation
on:

Refractive
Surgery

Cataract Surgery

Eye Muscle
Surgery

Date: _____

To: _____

Reason for request: _____

I, _____, DOB _____

Hereby authorize you to release my records to the above listed office,
including the diagnosis, records of any treatment or examinations rendered to
me and glasses/contact lens prescriptions for year(s): _____.

Signature

Date

Witness

Date