Retina & Macular
Disease Specialists

Date: _____

Patient Name: _____

Date of Birth: _____

I hereby request my medical records be released to:

Lindsay Smithen, MD
Retina & Macular Disease Specialists
3801 Fairfax Drive
Arlington, VA 22203

703.841.2310
571.410.4104 (fax)
retinamaculadocs@gmail.com

Patient Signature: _____ Date: _____