



Which location would you like your records transferred to (check one):

2791 S. Queen St.  
Dallastown, PA 17313  
Phone: (717) 741-4788  
Fax: (717) 741-5945

2155 White St.  
York, PA 17404  
Phone: (717) 848-4654  
Fax: (717) 848-2118

2700 Eastern Blvd.  
York, PA 17402  
Phone: (717) 757-7023  
Fax: (717) 757-6517

**REQUEST FOR TRANSFER OF RECORDS**

ATTENDING DOCTOR: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
PHONE# : \_\_\_\_\_  
FAX# : \_\_\_\_\_

I hereby agree that the above named doctor may disclose any and all information concerning my eye and visual status to **Weaver Eye Associates** while acting in a professional capacity, waiving all provisions of law to the contrary, including photographs.

PATIENT'S NAME: \_\_\_\_\_  
PATIENT'S ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
PATIENT'S PHONE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

(Patient, Parent, or Guardian Required)