



Authorization to Release Healthcare Information

Patient's Name: _____ DOB: _____

I request and authorize _____ to release my
(Name of your eye doctor or clinic)

- Previous examination records
- Eyeglass Prescriptions
- Contact Lens Prescriptions

to:

Select which office you would like your records sent to:

<input type="checkbox"/> 3214 Charles B Root Wynd Suite 120 Raleigh, NC 27612 Ph: 919-881-0900 Fax: 919-881-0911	<input type="checkbox"/> 3603 Davis Drive Suite 100 Morrisville, NC 27560 Ph: 919-234-4888 Fax: 919-234-4890
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Patient/Guardian/Parent Signature _____ Date: _____

Print Name: _____