

PERMISSION TO RELEASE RECORDS FOR TREATMENT PURPOSES

New Bern Family Eye Care
2805 Village Way
New Bern, NC 28562
(252) 633-0016
Fax: (252) 636-3895

Pamlico Family Eye Care
P.O. Box 219
Alliance, NC 28509
(252) 745-4100
Fax: (252) 745-3909

Patient: _____

DOB: _____

I grant permission to release my patient records to:

- Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____

Or

- New Bern Family Eye Care
2805 Village Way
New Bern, NC 28562
P: 252-633-0016
F: 252-636-3895

The medical findings and treatment disclosed should cover the period of time from _____ to _____. In initiating this request, I hereby release my practitioner from any laws governing the disclosure of confidential or privileged information.

Signature of Patient, Parent, Guardian or Personal Representative Date

Please print name of Patient, Parent, Guardian or Personal Representative Date

Date

Expiration Date: _____