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_____ Date_____

I grant permission to this office to release my patient records to _____.
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

Expiration Date: _____