FAMILY EYE CARE MEDICAL RECORDS RELEASE FORM

PATIENT NAME: _____
DATE OF BIRTH (DOB): _____

I grant permission to release my patient records to:
Recipient Name: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Fax: _____

OR (Please check one of the following offices):

☐ **New Bern Family Eye Care / SpecialEyes**
2805 Village Way
New Bern, NC 28562
P: (252) 633-0016 F: (252) 636-3895

☐ **Pamlico Family Eye Care**
PO Box 219
Alliance, NC 28509
P: (252) 745-4100 F: (252) 745-3909

☐ **Creekside Family Eye Care**
2038 Waterscape Way
New Bern, NC 28562
P: (252) 862-3840 F: (252) 862-3059

Disclosure Period or Specific Records Requested
This authorization applies to records from:
Start Date: _____ to End Date: _____
OR the following specific records: _____

Authorization and Consent
I have read and understand this form. I voluntarily authorize the disclosure of my health information as described.
If I am signing for a minor child, I attest I have legal authority to make medical decisions for the designated minor.

Signature: _____
Print Name: _____
Date: _____ Expiration Date of This Authorization: _____