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

☐ Pamlico Family Eye Care
13820 Hwy 55
Alliance, NC 28509
P: 252-745-4100
F: 252-745-3909

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: _______________________________