AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

REQUEST FOR RELEASE OF MEDICAL RECORDS TO FAMILY EYE WELLNESS

I hereby request and authorize

____

(Doctor/Practice Name) **(Fax Number)**

to release the ALL records of treatment I have received to:

Family Eye Wellness

Pooja J. Patel, OD, FAAO
135 Rosewood Centre Drive
Holly Springs, NC

Phone: 984-297-8400

Fax: 984-263-2914

X ____

Signature of Patient/Parent/Authorized Representative **Date**
(Guardian or Authorized Representative must attach documentation of such status)

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Printed name of Patient/Parent/Authorized Representative **Relationship to Patient**

Date of Birth: ____