

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

I consent and authorize you to release copies of my medical records.

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patients Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I request my records be sent from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to:

Digby Eye Associates

2401-D Hickswood Road

High Point, NC 27265

Fax: 336-454-1329

* I request my records be sent / transferred to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Also, include any information from any other medical doctor’s office that would be pertinent to my care.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ Authorized Signature (Patient, Guardian, or POA) Date

If POA, we must have a copy of the power of attorney on file. Please send a copy with the release.