WESTERN WAKE EYE CENTER, P.A.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

*** A medical records fee of $3.00 to $10.00 will apply. ***

Patient's Name____

Date of Birth____

Daytime Telephone Number______________________________________

I HEREBY AUTHORIZE: Western Wake Eye Center, P.A.
400 Ashville Ave, Ste. 300
Cary, N.C. 27518-6134
919-233-2020 Fax 919-859-5258

____**To Release Information To:**
____**To Receive Information From:**

____
Name of Person or Organization

____
Street Address

____
City, State, Zip Code

______________________________ ______________________________
Phone Number Fax Number

THIS RELEASE INCLUDES ___All Records ___Date of Service
___Lab ___X-Ray Reports
___Other______________________

This authorization shall be valid until written notice is received. I further understand that I have a right to receive a copy of this authorization upon request.

______________________________ ____________________
Patient Signature Date

______________________________ ____________________
Parent, Guardian or Authorized Representative Date