



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Information:

Name:		
Address:		
City:	State:	Zip:
Phone:	Date of Birth:	

Request Medical Information FROM: AEC Other (fill in below)

Physician/Practice Name:			
Address:			
City	State:	Zip:	Phone:

To be sent TO: Albemarle Eye Center

- 1730 Carolina Ave. Washington, NC 27889
- 101 Mark Dr. Edenton, NC 27932
- 1503 North Road St. Elizabeth City, NC 27909
- 2511 North Queen St. Kinston, NC 28501
- 3524 North Croatan HWY Kitty Hawk, NC 27949

OTHER

Physician/Practice Name:		
Address:		
City:	State:	Zip:

Complete medical records in your possession concerning my illness and/or treatment during the period from _____ to _____.

Reason(s) for Records Request:

- Moving out of area Copy for another physician Insurance change
- Primary physician needs records Change of provider Other (please explain)

I authorize the release of information including diagnosis, records, examination rendered to me, and claims information. This release of information will remain in effect until terminated by me in writing.

***Please allow up to 30 days for request to be processed*.**

Signature of Patient/Legal Representative

Date

FOR OFFICE USE ONLY	
Release Records of Dr.	Approved by Dr.
Date:	Request Completed By: