Advanced Eye Care
3702 W. Gate City Blvd.
Greensboro, NC 27407
336-854-2020
Fax: 336-852-9472

Davis Eye Associates OD, PA
3316 Silas Creek Parkway
Winston Salem, NC 27103
336-765-5350
Fax: 336-765-0769

Family Vision Clinic
4514 Oleander Drive
Wilmington, NC 28403
910-392-4414
Fax: 910-392-3153

Jefferson Village Eye Care
1600 Highwoods Blvd
Greensboro, NC 27410
336-297-4731
Fax: 336-297-4736

Records Release Authorization

To: _____ Date: _____

Patient Name: _____ DOB: _____

Rights of the Patient/Guarantor:

I understand that by signing this form I authorize the release of information to:

_____

from the named entity. I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. I understand that information disclosed as a result of this authorization may be subject to disclosure by the recipient and may not longer be protected by federal or state law. I understand that I have the right to revoke this authorization by sending a written notification to the address listed above and that a revocation is not effective if the information has already been disclosed. I understand that I have the right to inspect or copy the protected health information as described in this document by written notification.

Please include the following information: Recent best corrected visual acuity, recent spectacle prescription, recent contact lens prescription, cup to disc ratios, intraocular pressures and visual fields.

_____

Signature of Patient or Guarantor Date