Authorization for Release of Medical Records

Patient information (please print):

Name: ________________________________ Date of Birth:________________.

Address: ____

City: ______________________________ State: _________ Zip: ____________

Release my medical records from:

Office/Doctor's name: _____________________________________

Telephone: ______________________ Fax: _____________________

To:

Dr. Laura Young
Premier Family Eye Care
Fax: (704) 821-3938

Please release a copy of all medical records, including but not limited to, progress notes, laboratory results and diagnostic tests. They are for reference only.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

Patient: __________________________________ **Date:** ______________________