Records/Information Release Form

Patient Name:_____

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Birth Date:_____

Records/Information to be Released

I authorize my health care professional to release the following information from my health record(s).

! Complete Record
! Photos, Topography and Visual Fields
! Other (specify)_____

Records/Information to be released to / from:

Carrboro Family Vision, LLC
Dr. Matthew D. Vizithum
Dr. Jason Chow
200 West Weaver Street, Suite 1
Carrboro, NC 27510

(919) 968 – 6300
(919) 968 – 0403 (fax)

Records/Information to be released from / to:

Doctor:_____

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Telephone:_____ Fax:_____

Consent:

I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. The facility, its employees and attending physician are released from legal responsibility and liability for the release of the above information to the extent indicated and authorized herein.

Patient Signature:_____
Date:_____