RECORDS RELEASE AUTHORIZATION

Concord Eye Care Center
2351 Concord Lake Road
Concord, NC 28025
Phone: 704-788-1170
Fax: 704-788-2165

I consent to the above-named agencies, organizations, or individuals to release, exchange, and/or communicate with one another the information that is listed below. I understand that the information released may include information regarding HIV/AIDS information.

I hereby authorize and request you to release my complete medical history records in your possession concerning my condition, illness, and/or treatment to:

Recipient: ____

Address: ____

Phone: _________________________ Fax: ___________________________

Patient Name: ____

Date of Birth: ____

Address: ____

Patient Signature: ______________________________ Date: ___________

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