Burgaw Eye Center

106 E Satchwell St. PO Box 787, Burgaw, NC 28425
(910) 259-5661 Phone
(910) 300-6341 Fax

Information & Records Release Consent Form

Patient Name: _____ Date of Birth: _____

Facility where information is being requested: _____

Fax #: _____ Phone#: _____

I, _____, hereby authorize the above named facility to release all information and records concerning me to Burgaw Eye Center.

The information that I would like to have released is as follows:
Entire Medical Record _____
Dates of service from _____ to _____
Surgical reports: _____

Please: Mail ____ / Fax ____ my records to Burgaw Eye Center as quickly as possible to the above specified address/fax number with heading “Attention: Katie Davis”.

My appointment with Burgaw Eye Center is scheduled for: _____

I fully understand the release of my health records and I am requesting this information voluntarily. This release is good for any records that I have today and in the future that may be requested by this same facility.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____