



CAROLINA EYE SPECIALISTS

Authorization for Release of Medical Records

Print Patient's Full Name

Date of Birth

Address

Social Security

At my request, I _____ do hereby authorize release
of the following information checked off below:

____ Office Medical Notes

____ Visual Fields

____ Labs

____ Radiology Results

Please Release To: Carolina Eye Specialists
700 Tilghman Dr. Suite 722
910 980 0077 Office Number
910 980 1303 Fax Number

Signature of Patient

Date

Witness

Date