Cape Fear Cataract & Cornea, P.A.

1915 S. 17th Street, Suite 101

Wilmington, NC 28401

910.769.4590 **910.769.4653**

Authorization for Disclosure of Health Information

Patient Name: _____

Date of Birth: _____

Address: _____

Telephone: _____

I am requesting my records be sent FROM: _____

PHONE: _____

FAX: _____

Please send my records TO:

Cape Fear Cataract & Cornea, P.A.

1915 S. 17th Street, Suite 101

Wilmington, NC 28401

Phone: 910.769.4590 Fax: 910.769.4653

Covering the period of healthcare from _____ to _____

I understand this could include information about AIDS, HIV, behavioral or psychiatric care or drug use.

I understand that this authorization may be revoked in writing at any time.

The facility, employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information.

Signed: _____ Date: _____

Or Legal Representative: _____ Date: _____

Signature of Witness: _____ Date: _____