

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
 Or Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_  
 Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_

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.

I understand this could include information about AIDS, HIV, behavioral or psychiatric care or drug use.  
 Covering the period of healthcare from \_\_\_\_\_ to \_\_\_\_\_

Phone: 910.769.4590 Fax: 910.769.4653

Wililmington, NC 28401  
 1915 S. 17<sup>th</sup> Street, Suite 101  
 Cape Fear Cataract & Cornea, P.A.

Please send my records TO:

Patient Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Telephone: \_\_\_\_\_  
 I am requesting my records be sent FROM: \_\_\_\_\_  
 PHONE: \_\_\_\_\_  
 FAX: \_\_\_\_\_

Authorization for Disclosure of Health Information

Cape Fear Cataract & Cornea, P.A.  
 1915 S. 17<sup>th</sup> Street, Suite 101  
 Wilmington, NC 28401  
 910.769.4590 910.769.4653

