TRIANGLE
FAMILY EYE CARE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Triangle Family Eye Care
1216 Village Market Place
Morrisville, NC 27560
919-459-5995 Office Phone
877-719-7690 FAX

Patient's Name_____Date of Birth_____

I hereby authorize_____to release the
(Name of Doctor or Clinic)

following information (please check any that apply).

_____ Spectacle Prescription

_____ Contact Lens Prescription

_____ Visual Field Records

_____ All records

Please reference above contact information for our office for any correspondence related to records release. Thank you for your cooperation in the care of our mutual patient.

Patient/Guardian Signature:_____

Date Signed:_____