REQUEST FOR RELEASE OF MEDICAL RECORDS TO BRIER CREEK VISION CARE

I hereby request and authorize

_____

(Doctor/Practice Name) (Fax Number)

to release the *indicated records of treatment* I have received to:

Brier Creek Vision Care
Susan L. Durham, OD, FCOVD
Pooja J. Patel, OD, FAAO
Esther Nakagawara, OD, FAAO
9650 Brier Creek Parkway,
Suite 107
Raleigh, NC 27617
Phone: 919-361-2299
Fax: 919-361-0055

I consent that typing my name below will act as my signature.

Patient Name: _____ DOB: _____

Date of Request: _____

_____

Office use only:
RECORDS OF TREATMENT REQUESTED: _____