

Request For Release of Medical Records

To: _____

Patient Name _____

Address _____

Date of Birth _____

Please forward the following information:

All Records

Other _____

Send to the attention of Dr. _____

At the following checked location:

The EyeCare Group
1402 Eastchester Drive
High Point, NC 27265
Tel: (336) 886-8400
Fax: (336) 886-1800

The EyeCare Group
801 East Center Street
Lexington, NC 27292
Tel: (336) 249-8901
Fax: (336) 248-2695

Signed _____

Date _____