Wilson Eye Associates, Optometrists, PA
2402 Montgomery Drive SW
Wilson, NC 27893
Phone (252) 243-2020 *** Fax (252) 291-2020

Request for Release of Medical Records to Wilson Eye Associates

I authorize the release of all my medical records including protected health information in your possession. This authorization includes all information generated by you or a third party, but is in your possession. My records or a copy of my records is to be released to Wilson Eye Associates at the mailing address or by facsimile listed at the top of this form.

Release To: **Wilson Eye Associates**

Release From: Name: ____

Address: ____

Phone: (____) _____ ________ Fax :(____) ______ ________

The authorization for the release of my medical records is being issued at my request. If I wish to revoke it in the future, I will notify your facility in writing. I understand should I choose to revoke this authorization that actions already taken in reliance upon the authorization cannot be reversed. This authorization expires 1 – year from the date of my signature.

I have read and understand this form and I am signing it voluntarily.
I authorize the disclosure of my health information as described in this form.

______________________________ ______________________________
Patient or Authorized Signature | Relationship, if other than patient

______________________________ ______________________________
Witness Signature | Date

Patient Information, (please print clearly)

Name: ____ Date of Birth: ______________________

Address: ______________________________________

Phone: ____

Kevin G. Payne, OD | Russell B. Stone, OD | Matthew C. Aldrich, OD
Ralph B. Perry, OD | Ralph B. Perry, Jr. OD

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