SpectrumEyeCenter

160 Fox Hollow Court
Pinehurst, NC 28374
(910) 692-3937
myspectrumeyes.com

Patient Name:_____

Street Address:_____Date of Birth :_____

City, State, Zip:_____Phone:_____

Release information from:

Name (facility, person, company):_____

Address:_____ City, State:_____

Phone:_____ Fax:_____

Release information to:

Name (facility, person, company):_____

Address:_____ City, State:_____

Phone:_____ Fax:_____

Medical records release:

☐ All medical records ☐ All medical records from last 3 years ☐Last glasses prescription

☐_____

Delivery Method: ☐Mail ☐Pickup ☐Fax ☐ Other_____

I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law. I understand that I can cancel this authorization at any time. I must cancel in writing and send or deliver the cancellation to the releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice. I understand that I may refuse to sign this. I understand that the information in my medical record may include information relating to treatment for drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted diseases, HIV/AIDS and or Aids related complex (ARC).

Signature:_____Date:_____

Print Name:_____

☐Patient ☐Guardian ☐Parent ☐Other:_____