REQUEST FOR RELEASE OF MEDICAL RECORDS

PHYSICIAN'S NAME/MEDICAL OFFICE (PLEASE PRINT)

PHONE/FAX NUMBER

ADDRESS

CITY **STATE** **ZIP CODE**

I HEREBY REQUEST THAT MY MEDICAL RECORDS BE RELEASED TO:
Haywood Family Eye Care,O.D., PLLC
Dr. Aimee McBride, O.D.
Dr. Thomas Pinkston, O.D.
29 North Main Street
Waynesville, N.C. 28786
(828)456-8361
FAX:(828)452-4527

PATIENT'S NAME (PLEASE PRINT)

PATIENT'S SIGNATURE **DATE**

ADDRESS

CITY **STATE** **ZIP CODE**

BIRTHDATE **SOCIAL SECURITY NUMBER**