Chapel Hill Eyecare
Healthy Eyes for a Lifetime℠

235 S. Elliott Rd
Chapel Hill, NC 27514
P 919.968.4774 F 919.942.5291
Dr. Laurel Gropper & Dr. Scott Sikes

# Authorization for Release of Records

Patient Name: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Date of Birth: _____

I, _____ hereby request that the following information:

- ☐ Ophthalmologic records (including photos, visual fields, special reports and other data pertinent to my ophthalmologic treatment)
- ☐ Most Recent Lab Work
- ☐ Current Medications / Pertinent Systemic History

(Please choose one)

1. Be released to: Chapel Hill Eyecare, Dr. Laurel B. Gropper & Dr. Scott Sikes
   235 S. Elliott Rd, Chapel Hill, NC 27515
   Telephone: 919-968-4774 Fax: 919-942-5291

2. Be released to: _____
   _____

I understand that this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. The facility, it's employees, and attending physician are released from legal responsibility and liability for the release of the above information to the extent indicated and authorized herein.

Patient Signature: _____

Date: _____

Thank you for your prompt assistance with this request.