RELEASE OF RECORDS

WOLFEBORO EYE ASSOCIATES

36 CENTER ST., SUITE 5 -PO BOX 1196

TELEPHONE: (603) 569-8500

FAX:(888) 972-3566

www.wolfeboroeye.com

Patient Name:_____ **Date of Birth:**_____

I,_____, consent to sharing information that may include diagnosis, records, or any previous examination or treatment and any additional facts and observations related to vision care, other health services, or education-depending on which services are being provided. I also understand that this information cannot be released without my consent (except in medical emergencies, for an audit, or with a court order) and that I have the right to revoke my consent at any time.

I authorize Wolfeboro Eye Associates (WEA) to :

☐**Send/disclose information to:**
Name: _____
Address:_____
_____

☐**Receive information from:**
Phone: _____
Fax:_____

For the following purpose(s):

☐Concurrent Care ☐Transfer of care ☐Personal Records ☐Other:_____

Type of information requested:

☐Most recent office visit ☐Spectacle/Contact lens Prescription ☐Operative Reports
☐Diagnostic testing ☐All records ☐Other:_____

Date of care to be released: _____ **To:** _____

_____ _____

Signature of Patient or Legal Representative/Guardian **Date**