RELEASE OF RECORDS

WOLFEBORO EYE ASSOCIATES

36 Center St. Suite 5, PO Box 1196
Wolfeboro Falls, NH 03896
Telephone: (603) 569-8500
Fax: (603) 569-8905

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

I, _____, consent to your 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 emergency, 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:** □ **Receive information from:**

Name: _____ Phone: _____

Address: _____ Fax: _____

_____

For the following purpose(s):

□ Concurrent Care □ Transfer of Care □ Personal Records □ Other: _____

Type of information requested:

□ Most Recent Office Notes □ Spectacle/Contact Lens Prescription □ Operative Reports

□ Diagnostic Testing □ All Records □ Other: _____

Dates of care to be released: _____ **to:** _____

_____ _____

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

_____

Witness

OFFICE USE ONLY

Date received: _____ *Date completed:* _____ *Initials:* _____