RECORDS RELEASE

TODAYS DATE: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT ADDRESS: _____

_____

PATIENT PHONE: _____

I, _____, hereby authorize you to release my complete medical records to Buglisi Eye Care,PLLC.

_____ _____

Patient's Signature Witness Signature

1021 Hargett St, Jacksonville, NC 28540 Phone 910.378.8131 Fax 910.238.2495