Records Release Authority

I, _____(patient name), hereby request that you release my medical records accordingly by this authorization. This authorization is valid for one year from date of signature below.

My records from:

□ Eye Care of Edenton
Dr. Stephen P. Benkusky, O.D.
111 Virginia Road * Edenton, NC 27932
Tele: (252) 482-3218
Fax: (252) 482-8444

□ _____
_____
_____
_____
_____

to be sent to:

□ Eye Care of Edenton
Dr. Stephen P. Benkusky, O.D.
111 Virginia Road * Edenton, NC 27932
Tele: (252) 482-3218
Fax: (252) 482-8444

□ _____
_____
_____
_____
_____

I further request the following information to be released:

□ Complete medical records, including all diagnostic testing, diagnosis, treatment, prognosis, and recommendations
□ Exam date range _____ to _____
□ Glasses and/or contact lenses prescription

Patient Name: _____ DOB: _____

Address: _____

_____

Patient Signature (Guardian Signature): _____

Witness Signature: _____

Date of Request: _____