VISION SOURCE MOREHEAD CITY

A MEMBER OF Vision Source

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

I hereby authorize:

_____
Name of Party

_____
Address

_____
City State Zip

_____ _____
Phone Number Fax Number

To disclose to:

Dr. Patrick A. Patterson, O.D.
Dr. Angela B. Gray, O.D.

Vision Source Morehead City
4254 Arendell Street, Suite G
Morehead City, NC 28557

Phone: (252)-728-3618
Fax: (252)-838-0013
Email: admin@visionsource-morehead.com

Patient Health Information Pertaining To:

_____ _____ _____
Name of Patient Date of Birth Last 4 of SS

_____ _____ _____ _____
Address City State Zip

_____
Phone Number

Specify Records:

- ☐ A copy of my medical eye records only
- ☐ A summary of my diagnosis and treatment
- ☐ Other health information: _____

A copy of this authorization is as valid as the original. Patient has a right to a copy of this authorization. This authorization is effective now and will remain in effect until one year after the date signed below.

_____ _____
Patient Signature Date