Mountain Eye
ASSOCIATES

RELEASE OF MEDICAL RECORDS

DATE;_____

PATIENT NAME:_____

ADDRESS:_____

_____

DATE OF BIRTH:_____

I hereby authorize Mountain Eye Associates, PLLC to release my entire medical record to:

_____

_____

_____

Patient or Legal Guardian Signature:_____

Witness Signature:_____

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65 Park Street, Canton, NC 28716 828.648.2483
1898 S. Main Street, Waynesville, NC 28786 828.456.2015

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