1319 White Mountain Hwy
North Conway, NH 03860
Phone: 603-356-3000
Fax: 603-356-4101

CONWAY EYE CARE
COOS EYE CARE

www.conwayeye.com

820 Main St
Berlin, NH 03570
Fax: 603-752-3510
Phone: 603-752-6887

Authorization to Release Medical Records

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

Address: _____ **Phone:** _____

Choose one of the following:

[ ] Please release my records (including eyeglasses and contact lens prescriptions) ***FROM*** Conway Eye Care / Coos Eye Care and ***SEND TO*** the following location:

OR

[ ] Please release my records (including eyeglasses and contact lens prescriptions) ***TO*** Conway Eye Care / Coos Eye Care, to be ***SENT FROM*** the following location:

Location Information:

Name:_____

Address:_____

Phone Number: _____ Fax Number: _____

Choose one of the following:

[ ] I am only interested in obtaining a copy of my **most recent** medical record.
There is no additional charge for this service. _____ Patient Initials

[ ] I am interested in obtaining a copy of **all** medical records on file.
I am aware that there may be a charge of $0.50 per page. _____ Patient Initials

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This authorization is valid for 60 days from the date of execution. A photocopy of this authorization shall have the same force and effect as an original. **Please allow up to 30 days for processing of records release.**

_____ _____
Patient/Representative Signature Date

_____ _____
Optometrist Signature Date