



EYE ASSOCIATES OF WILMINGTON, P.A.

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Authorization for Disclosure of Health Information

1. Patient's Name _____
 Date of Birth _____
 Telephone _____
 Address _____
2. I am requesting that my records be sent FROM: _____
 (Dr./Medical Facility)
3. Please send records TO: _____
 (Dr./Medical Facility/Self)
4. Covering the period of healthcare from _____ to _____
5. I understand this could include information about AIDS, HIV, behavioral or psychiatric care, alcohol or drug abuse.
6. I understand that this authorization may be revoked in writing at any time.
7. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information.
8. Please allow several business days for processing.

Signed: _____
 (patient) (date)

_____ or (legal representative) (relationship to patient) (date)

_____ (signature of witness) (date)