235 S. Elliott Rd
Chapel Hill, NC 27514
Dr. Scott Sikes & Dr. Laurel Gropper

## Authorization for Release of Records

Patient's Name: ______________________________________________

Mailing Address: ______________________________________________

City: ____________________ State: _________ Zip Code: __________

Phone Number: ___________________________________

**I hereby authorize:**

Chapel Hill Eyecare
Dr. Scott Sikes & Dr. Laurel Gropper
235 S. Elliott Rd, Chapel Hill, NC 27514
Telephone: 919-968-4774 Fax: 919-942-5291

**To release information to / To receive information from:**

Name of organization / person: _____________________________________

Mailing Address: ______________________________________________

City: ____________________ State: _________ Zip Code: __________

Phone Number: ___________________ Fax Number: _________________

This release includes: **All Records**

This authorization shall be valid until written notice is received. I further understand that I have a right to receive a copy of this authorization upon request.

Patient Signature: ______________________________ Date: __________

Thank you for your prompt assistance with this request.