Records Release Request

I hereby request and authorize_____
(office name) (fax number)
to release any and all records of treatment that I have received to:

Brier Creek Vision Care

Dr Susan Durham, OD, FCOVD

10207 Cerny Street, Suite 100

Raleigh, NC 27617

Phone: (919) 361-2299

Fax: (919) 361-0055

Patient Name: _____ Date of Birth:_____

Patient Signature: _____

Date of Request: _____