Adler Eye Associates o.d., p.a.
AdlerEyeAssociates.com
919-929-7111
Center for Visual Excellence

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REQUEST FOR TRANSFER OF RECORDS

Attending Doctor: ____

I hereby agree that the above named doctor may disclose any and all information concerning this patient's eye and visual status, while acting in a professional capacity, waiving all provisions of law to the contrary, including photographs.

Patient's Full Name: ____

Date of Birth: ____

Current and/or Previous Address: ____

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Current Telephone Number: ____

Signature: ______________________________ Date: ____________________
(Patient, Parent, or Guardian)