SOUTHEASTERN OCULARISTS, INC.
Custom Made Ocular Prosthetics

Authorization for the Release of Medical Records

I, the undersigned, hereby authorize any physician's office, hospital, or medical entity that has treated me for any and all medical conditions to release the medical records of:

Patient Name: _____ DOB: _____
Address: _____
Phone Number: _____

To: Southeastern Ocularists, Inc
8426 Medical Plaza Dr, Suite 500, Charlotte, NC 28262

P: 704-510-9292 F: 704-510-9881
E: seocularists@gmail.com

Purpose of Request: To obtain prior authorization and for use as proof of medical necessity with regards to the patient's insurance only.

Information Requested:
□ Progress Notes □ Operative Reports □ Hospital Reports

This authorization is subject to cancellation/revocation at any time, by the patient or legally qualified representative, provided that the cancellation is made in writing, except to the extent that:

1. The facility has already acted on your request prior to receiving the request to cancel the authorization; or
2. If the authorization was given to release records to your insurance company in order to obtain insurance coverage.

I understand that these records are protected under Federal and/or State Law, and cannot be disclosed without my written consent, unless otherwise provided by law.

By my signature below, I hear by, knowingly and voluntarily, authorize Southeastern Ocularists, Inc to request my health information.

_____ _____
Printed Name of the Patient Date

_____
Patient's Signature

_____
Guardian or Authorized Representative's Signature