Chapel Hill Eyecare
OD, PLLC Healthy Eyes for a Lifetime™

101 Cosgrove Ave, Ste 170
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
101 Cosgrove Ave, Ste 170
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.