Please Fax records requested to
Decatur Eye Care : (f)404-371-9384.

Authorization to Release Health Care Information

Patient's Name _____

Date of Birth _____

I request and authorize _____ to release health care information to the patient named above to:

Decatur Eye Care
321 West Hill Street
Suite 6
Decatur, GA 30030
404-371-8777 phone
404-371-9384 fax

We are requesting:

_____ Contact Lens Rx

_____ Spectacle RX

_____ Medical Records

Signed: _____ Date: _____