AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

_____

Name of Facility

_____

Address

_____

City, State, Zip Code

You are hereby authorized to release all medical records, x-ray reports, lab reports, medical history, and all other information to:

Weeks Cataract and Eye Center
2871 Corporate Park Drive
Opelika, AL 36801
Fax-334-887-2030

For the following purpose or need: Transfer of Records of

_____ _____

Patient's Name (PRINT) Date of Birth

It is understood that this authorization is revocable except to the extent that action has been taken in reliance thereon, and this authorization will remain in force but, not to exceed on year, in order to effectuate the purpose for which it was given. Auburn Cataract and Eye Clinic, LLC is released from all legal responsibilities that may arise from this act.

_____ _____

Witness Patient's Signature

_____

Date