



Dr. Travers may require a copy of your previous eye records to provide you the best possible care. Please take a moment to fill out your eye doctor's information.

RELEASE REQUEST OF MEDICAL INFORMATION

TRAVERS LASIK VISION CARE

I, _____ DOB: _____

Authorize my eye doctor: _____

Address: _____

Phone: _____

Fax: _____

To release all medical records pertaining to my health / eye examinations and treatment to:

Travers Lasik Vision Center
2501 Atrium Drive Suite 200
Raleigh, NC 27607
Phone# (919) 510-6830
Fax # (919) 510-6835

Patient Signature

Witness Signature