Medical Records Release

(Name of Patient) (Birthdate)

(Street Address) (City, State, Zip Code)

Telephone number:

Authorizes Release of Medical Records to ☐ from ☐ :

(Name of Physician) (Street Address)

(Name of Health Care Facility (City, State, Zip Code)

(Telephone number) (Fax number)

Authorizes Release of Medical Records to ☐ from ☐: Texan Eye, P.A. Telephone: 512-327-7000

☐ 5717 Balcones Dr., Austin, TX 78731 ..... Fax: 512-314-1662

☐ 1700 S. MoPac Expy, Austin, TX 78746..... Fax: 512-327-5200

☐ 925 Starwood Dr., Cedar Park, TX 78613 ..... Fax: 512-259-3802

Information to be released:

☐ All Clinic Records
☐ Office Notes
☐ Photographs (Charges may apply)
☐ Visual Fields
☐ X-Ray Reports
☐ Lab Reports
☐ Other (Specify)

For the Following Dates: ☐ **All dates of services**

Purpose or need for disclosure: (check applicable categories)

☐ Further medical care
☐ Application for insurance
☐ Disability determination
☐ Payment of insurance claim
☐ Other (Specify)

I understand that this authorization shall be valid for one (1) year unless otherwise stated below or revoked through written notice to Medical Records.

(Alternate date if not (1) year)

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed above. This authorization may include disclosure of information relating to alcohol and drug abuse, sexually transmitted diseases, mental health treatment, except psychotherapy notes and confidential acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient/Parent: _____ Date: _____

For internal use only:*(Date and initial)*

Date Received: _____ Request Verified:_____ Date Completed: _____