

REX W. COLE, M.D.
Diplomate American Board of Ophthalmology
JAMES E. PICKETT, M.D.
Diplomate American Board of Ophthalmology



JONATHAN C. WELCH, M.D.
Diplomate American Board of Ophthalmology
JOSHUA K. HU, M.D.
Diplomate American Board of Ophthalmology
TAMATHA TOMEFF, O.D.
78666 · Telephone (512) 353-1300 · Fax (512) 353-

1300 Wonder World Drive · San Marcos, Texas

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name _____ OTHER NAMES USED _____

Date of Birth ____/____/____ Dates of Service(s) _____

I HEREBY AUTHORIZE AND REQUEST YOU RELEASE MY MEDICAL RECORDS TO:

Central Texas Eye Center, P.A.
1300 Wonder World Drive · San Marcos, Texas 78666
Telephone (512) 353-1300 · Fax (512) 353-5135

FROM: ALL RECORDS _____ FOR TREATMENT _____ CONTINUITY OF CARE _____

Doctor: _____ Fax: _____

Address: _____ Telephone: _____

**I HEREBY AUTHORIZE AND REQUEST YOU RELEASE MY MEDICAL RECORDS FROM
CENTRAL TEXAS EYE CENTER**

TO:

Name/Dr. _____ Fax: _____

Address: _____ Telephone: _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire 1 year from the date of my signature unless I revoke the authorization prior to that time.

Signature of Patient or Legal Representative

Date

Relationship to Patient (If Legal Representative)

Printed Name of Patient or Legal Representative