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2430 S. IH 35 #106 · San Marcos, Texas 78666 · Telephone (512) 353-1300 · Fax (512) 353-Phone:512-353-1300 · Fax: 512-353-5135

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.
2430 S. IH 35 #106 • San Marcos, Texas 78666
Telephone (512) 353-1300 • Fax (512) 353-5135

ALL RECORDS _____ FOR TREATMENT _____ CONTINUITY OF CARE ____

FROM:

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

E-mail: info@ctectx.com
Website: www.ctectx.com