AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name:_____

Address:_____
Street City State Zip

Date of Birth:_____ Date Records Requested:_____

I, patient undersigned below, authorize:

1st Eye Care
Gayle Karanges OD, Gina Seymour OD, Michelle Perry OD
2301 N. Collins #124
Arlington, TX 76011
Phone (817)860-9050 ·· Fax (817)274-3280

To release or obtain my medical records to/from the following:
Please circle: Release Obtain

Telephone #:_____ Fax#:_____

Please include complete medical records, including eye examinations or additional diagnostic testing.

The facility and its doctors are released and discharged from any liability, and the undersigned will hold the facility and its doctors harmless for complying with this authorization.

Patient
Signature:_____Relationship:_____Date:_____

Notice to Person or Agency receiving this information: This information has been disclosed to you from records whose confidentiality is protected. Statutes and regulations prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.