OST VISION FOR THE FUTURE
OPHTHALMOLOGY SPECIALIST OF TEXAS PLLC

Medical Records Release Form

Print or type

Name:_____
Last First Middle

Social Security # last 4 digits_____ Date of Birth _____ Phone_____

Please give name and address of medical facility you are authorizing your medical records released from:

Physician/Clinic:_____
Address:_____
Phone_____
Fax_____

I authorize my medical records to be released to:

Name:_____
Address_____
Phone:_____
Fax:_____

Check all records to be released

_____Labs/Test Results
_____ All Medical Records
_____Billing Records
_____Follow Up Exams
_____Other (specify)_____

Initials Required For Release of The Following Information

_____Mental Health
_____Drug/Alcohol
_____HIV/AIDES Tests/Treatment
_____Genetic Information

Purpose of records being released:

_____Continuity of care _____Personal copy _____Insurance claim
_____Legal claim _____Disability claim _____Other(specifiy)_____

This authorization is in effect from _____ to_____. Upon conclusion of this time, this authorization is automatically revoked.

I understand that:

- I may refuse to sign this authorization and that my refusal has no impact on receiving treatment. The covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization
- I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission
- I can inspect or copy any information disclosed under this agreement
- My signing the document is voluntary
- I can revoke this authorization at any time, except to the extent that the practice has acted in upon this authorization and revocation must be in writing
- I can receive a copy of this authorization
- I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Patient/Legal Guardian Signature: _____ Date:_____