Eyelid Reconstructive Surgery
Orbit & Lacrimal Surgery
Cosmetic Facial Surgery

TOC
EYE AND FACE

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Authorization for Release of Information

Records requested:
_____ Complete medical records.
_____ Records of care from _____ to _____ only.
_____ Other (please specify) _____
_____ Confer with another person orally about information in my record. Specify person under "TO".

Reason for Release: (Article 4495b, Sec. 5.08(j) Texas Revised Civil Statutes require that an authorization for release of medical records include "the reason or purpose for the release.")
_____ Change of Physician or Patient Moving _____Workers' Compensation or Disability Claim
_____ Application for Insurance Coverage _____Other: _____
_____ Consultation with another physician for (condition): _____

Records Requested FROM:

_____
Physician's Name

_____
Address

_____
City/State/Zip

Send Records TO:

_____
Recipient's Name

_____
Address

_____
City/State/Zip

_____
(FAX including AREA CODE)

I understand that a reasonable amount of time (not to exceed 30 days) may be required to move my records. If possible, please send by: _____.

I, the undersigned, do hereby authorize the release of information described above from my medical records. I understand that reports may include information on drug/alcohol/psychological or communicable disease treatment. I understand that I may revoke this consent in writing at any time except to the extent that action has already been taken in reliance on it. A photocopy of this consent shall be considered valid. This authorization expires automatically in one year.

Patient's Full Name (Please Print): _____

Date of Birth: _____ Social Security #:_____ Year Last Seen: _____

Any other name(s) under which your records may be filed: _____

_____ _____
Patient's Signature Date

(Patient or person legally authorized to consent on patient's behalf. State relationship to patient and reason patient is unable to sign.) (Revised 06-14)