Authorization to Release Medical Records

Patient Information (Please Print):

Name: _____ Date of Birth: _____

Social Security Number: _____ Phone Number: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Release *from* (name of Physician or facility releasing information):

☐ Eyes of Texas, LLP or

Physician/Facility: _____ Phone Number: _____

Address: _____ City: _____ State: _____Zip: _____

Release *to* (name of Physician or facility receiving information):

☐ Eyes of Texas, LLP or

Physician/Facility: _____ Phone Number: _____

Address: _____ City: _____ State: _____Zip: _____

Reason for Release:

☐ Change of Insurance ☐ Transfer of Care ☐ Personal File

☐ Moving out of Area ☐ Specialist Consult ☐ Legal

Please Release the Following (check all that apply):

☐ Entire record ☐ Laboratory Results Only ☐ Angiography Photo*

☐ Last 3 Visits ☐ Other:

*Developing of copying costs apply.

Consent:

I understand this information is for use by the recipient named above. It cannot be given to any other individual or agency without the patient's written consent. I understand that the information is for the specific purpose stated above. I understand that the records release may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol abuse. I understand that the authorization is valid a ninety (90) day period from the date that is signed. I understand that I may revoke this consent at any time through the written notice. I understand that I have the right to receive a copy of this authorization.

Signature of patient: _____ Date: _____

I authorize the release of HIV/AIDS test results. Initials: _____

★ **Note: Please allow 15 days for processing. Incomplete information will delay processing.** ★

155 E. Loop 338 Suite 400 Odessa, TX 79762 Phone (432) 367-724 Fax (432) 550-3427