



RELEASE OF MEDICAL INFORMATION

Southlake

305 Morrison Park Drive, Suite 100
Southlake, TX 76092

Plano

3804 15th Street, Suite. 130
Plano, TX 75075

Fort Worth

3455 Locke Avenue, #310
Fort Worth, TX 76107

Dallas

12222 N. Central Expressway, Suite. 250
Dallas, TX 75243

I hereby authorize: _____
(Physician Office/Name)

To release the following information from the health records of:

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

Covering the period of treatment from _____ to _____

Information to be released:

- Narrative Summaries
- Medical Records (including copies of diagnostic testing)
- Complete Medical Records
- Financial and Billing Records

Other: _____

Purpose of Disclosure: Patient Referral

I understand that this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this content. If the revocation is not received, authorization will be considered valid for a period of time not to exceed 180 days.

List the date, event, or condition upon which this consent expires. The facility, its employees and officers, and attending physicians are released from legal responsibility or liability for releasing the above information to the extent indicated and authorized herein. I understand the information released could contain references to HIV antibody (AIDS) testing.

Patient Name

Date

Patient's Signature (or Authorized Representative/Guardian)

Information is to be released to Retina Center of Texas | 305 Morrison Park Drive, Ste. 100 | Southlake, TX 76092

**Please email this file along with the most recent chart notes to:
info@retinacentertx.com or fax it to (817) 865-6790**