RETINA CENTER OF TEXAS™

RELEASE OF MEDICAL INFORMATION

Southlake
305 Morrison Park Drive, Suite 100
Southlake, TX 76092

Fort Worth
3455 Locke Avenue, #310
Fort Worth, TX 76107

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

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

I hereby authorize: **Retina Center of Texas**

To release the following information from the health records of:

Patient Name: _____

Date of Birth: _____

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: _____

Information is to be released to: _____
(Physician Office/Name and Fax number)

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, revocation is not received, authorization will be considered valid for a period of time not to exceed 180 days.

List 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 the release of the above information to the extent indicated and authorized herein. I understand the information released could contain references of HIV antibody (AIDS) testing.

_____ _____
Patient Name Date

_____
Patient's Signature (*or Authorized Representative/Guardian*)