RETINA CENTER OF TEXAS™

RELEASE OF MEDICAL INFORMATION

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

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

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

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

Flower Mound
4951 Long Prairie Road
Suite #130
Flower Mound, TX 75028

Rockwall
1005 W. Ralph Hall Parkway
Suite #145
Rockwall, TX 75032

Alliance
10900 Founders Way
Suite #200
Fort Worth, TX 76244

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: _____

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 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