



## 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: **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)