

Authorization for Release of Medical Records



I authorize the following protected health information to be released from the medical record of:

Name of Patient

Street Address

City, State, Zip Code

Date of Birth

I understand that to the extent that any recipient of this information, as identified below, is not a "covered entity" under Federal or Texas privacy law, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to the recipient and, therefore, may be subject to re-disclosure by the recipient.

I understand that the information released is for the specific purpose stated below. Any other use of this information without the written consent of the patient is prohibited.

Release Records Texas Regional Eye Center
 From Attn: Medical Records
 To 3811 Sagebriar Drive
 Bryan, TX 77802
 Phone (979) 774-0498
 Fax (979) 774-7673

Release Records _____
 From Name/Organization
 To _____
 Address _____
 City, State, Zip _____
 Phone _____
 Fax _____

- Please mail my records Please call when my records are ready for pick-up Please fax my records

➔ **NOTE:** The Texas Medical Board allows a set charge for copying medical records. There is a \$25.00 charge for the first 20 pages or less, and \$0.50 per page after the first 20. Shipping or mailing cost will be added to the fee. The fee must be paid prior to the release of the health records unless requested by a health care provider for "acute" or "emergency" care. We will contact you with an amount prior to initiating the records release.

TO BE RELEASED	DATE OF SERVICE	TO BE RELEASED	DATE OF SERVICE
<input type="checkbox"/> Entire record	_____	<input type="checkbox"/> Pre-op calculations	_____
<input type="checkbox"/> Office visit reports	_____	<input type="checkbox"/> Post-op reports	_____
<input type="checkbox"/> Lab reports	_____	<input type="checkbox"/> Other (specify)	_____
<input type="checkbox"/> Radiology reports	_____	<input type="checkbox"/> Billing/ins. records	_____

➔ **NOTE:** If specific dates to be release are not provided, all records in the category marked will be released.

REASON FOR RELEASE OF INFORMATION

- Further medical care Patient's request Insurance/Eligibility/Benefits Disability Determination
 Legal Investigation Other: _____

I may revoke this authorization in writing at any time except to the extent that Texas Regional Eye Center has already relied on this authorization. I may revoke it by mailing or faxing a written notice to the Practice Administrator to the address/fax number above stating my intent to revoke this authorization. Unless otherwise revoked, this authorization expires upon completion of this request.

I understand that the records released may include information relating to Human Immunodeficiency Virus ("HIV") infection or Acquired Immunodeficiency Syndrome ("AIDS"); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care. I understand my treatment will not be conditioned by my completion of this form.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

DATE

RELATIONSHIP TO PATIENT (IF LEGAL REPRESENTATIVE)

DATE

Texas Regional Eye Center Staff Only: Date Released: _____ Released By: _____
 Physician's Signature: _____ Notes: _____