AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name: ____

Address: ____
Street City State Zip

Date of Birth:

Date Records Requested:

I, patient undersigned below, authorize:

Colleyville Vision Associates
Carolyn Helbert-Green, O.D.
1213 Hall Johnson, Suite 300
Colleyville, TX 76034
Fax (817)428-0457 • Telephone (817)428-0400

to release or obtain my medical records from the following doctor and address listed below:
Please circle: Release Obtain

____

____

____

Telephone # ____________________Fax # ____________________

Please include complete medical records, including eye examinations or additional diagnostic testing.

____

The facility and its doctors are released and discharged from any liability, and the undersigned will hold the facility and its doctors harmless for complying with this authorization.

Patient Signature______________________Relationship_________Date ___________

Notice to Person or Agency Receiving this Information: This information has been disclosed to you from records whose confidentiality is protected. Statutes and regulations prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.