TVLC

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Authorization for Medical Records Release

Patient Information:

Patient Name: _____

Date of Birth: _____ SSN# _____

Address: _____ City: _____ State: _____

Phone: _____ Email: _____

This information is to be released **TO**:

_____

_____

_____
City State Zip

_____ _____
Phone Fax

This information is to be released **FROM**:

_____

_____

_____
City State Zip

_____ _____
Phone Fax

Information being requested:

☐ Complete Record

☐ Records of care from the following dates: _____ to _____

State statute requires special permission to release otherwise privileged information. Please check applicable categories for release of records.

☐ Mental Health
☐ Developmental disabilities
☐ AIDS related diagnosis
☐ Alcoholism
☐ AIDS test results
☐ Drug abuse

Purpose or need for disclosure:

☐ Further medical care
☐ Payment of ins claim
☐ Vocational rehab eval
☐ Legal investigation
☐ Application for insurance
☐ Disability determination
☐ Personal
☐ Other

I hereby authorize the information indicated on this form to be released from and to the indicated parties. I understand that this authorization shall be valid for one (1) year unless otherwise stated on this form or through written notice to medical records. (Alternate date if not one (1) year _____). I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information that has been written in the record. I will not hold the Texas Vision & Laser Center liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

Patient Signature: _____ Date: _____

Signature of Legal Representative: _____ Date: _____

Relationship: _____ Witness: _____