Authorization for Release of Medical Records

TEXAS REGIONAL Eye Center

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
❑ **From**
☑ **To**

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

Release Records
☑ **From**
❑ **To**

Memorial Eye Center- Sugarland
15337 Southwest Freeway
Sugarland, TX 77478

Phone # 281-242-2020
Fax # 281-565-0888

❑ **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. The charge is $25 for the first 20 pages and $.50 per page for every copy thereafter. Shipping or mailing cost will be an additional charge. 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**

❑ Entire record _____

➡ 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

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.

❑ **Yes**, I consent to the release of this information. ❑ **No**, I do not consent to the release of this information.

_____ _____
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: _____