

Pediatric Ophthalmology, P.A. and the Center for Adult Strabismus

CYNTHIA L. BEAUCHAMP, M.D., F.A.A.P.

LORI DAO, M.D., F.A.A.P.

Fees for records \$25.00.

Please enclose payment.

ALAN D. DAVIS, M.D.

JOHN T. TONG, M.D., F.A.C.S.

ROBERT D. GROSS, M.D., F.A.A.P.

Medical Records Release

(Name of Patient)	(Birthdate)
(Street Address)	(City, State, Zip Code)
Authorizes:	Release of Records to:
(Name of Physician)	(Name of Physician)
(Name of Health Care Facility)	(Name of Health Care Facility)
(Street Address)	(Street Address)
(City, State, Zip Code)	(City, State, Zip Code)

Information to be Released:

All Clinic Records

Visual Fields

Lab Reports

Office Notes

X-Ray Reports

Other (Specify)

Photographs

List other facilities' records to be included when releasing for the purpose of continuing medical care:

For the Following Dates:

In compliance with state statutes which require special permission to release otherwise privileged information, please release records pertaining to:

Mental health

AIDS test results

Drug abuse

Developmental disabilities

AIDS-released disease diagnosis

Other

Alcoholism

Purpose or need for disclosure: (check applicable categories)

Further medical care

Payment of insurance claim

Legal investigation

Application for insurance

Vocational rehabilitation evaluation

Personal

Disability determination

Other (Specify)

I understand that this authorization shall be valid for one (1) year unless otherwise stated below or revoked through written notice to Medical Records.

(Alternate date if not (1) year)

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

Signature of Patient/Parent:

Date:

(if signed by person other than patient, state relationship and authorization to do so)

Patient is:

Minor

Incompetent

Disabled

Deceased

Legal authority:

Legal

Legal guardian

Next of kin deceased