NORTH TEXAS
EYE CONSULTANTS®

2301 S FM 51 STE 300
Decatur, TX 76234

PHONE (940) 600-5799 FAX (940) 600-5796

MEDICAL RECORDS RELEASE REQUEST

To:
Fax Number:

Patient Name:
Address:
Date of Birth:

I hereby authorize and request you to release to North Texas Eye Consultants the following records in your possession concerning my illness and/or treatment to assist in my further medical care.

Date(s):

___ All Dates

Record type(s):

___ All Records

___ Office Visit

___ Diagnostic Testing

___ Operative Reports

___ Other:

By signing this for you authorize the Practice to use and disclose protected health information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior authorization.

Patient/Authorized Signature: ________________________________
Relationship: _________________________
Date: ___________________