Texas Vision

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## Authorization for Release of Information

I, the undersigned, hereby authorize the below named doctor to release my medical information.

**FROM:**

| | |
|---|---|
| **Physician's Name:** | **Name of Practice:** |
| **Address:** Number Street Unit # City State Zip Code | |
| **Phone Number:** | **Fax Number:** |

**TO:** (If records are to be sent to Vision Center of Texas, please check this box ☐ and continue to "The Reason"

| | |
|---|---|
| **Physician's Name:** | **Name of Practice:** |
| **Address:** Number Street Unit # City State Zip Code | |
| **Phone Number:** | **Fax Number:** |

**The Reason For Request:**

☐ **Continuity of Care** ☐ **New Doctor** ☐ **Other:** ***(specify)***

I understand that my records are confidential and cannot be disclosed without written authorization, except as otherwise provided by law.
This authorization is valid for six (6) months and may be revoked by the patient, orally or in writing, at any time prior to the six month period.
The information released should include all histories, physical exams, progress notes, lab and Xray reports, mental health records, alcohol/substance abuse records, HIV records, and all correspondence relating to my medical care unless otherwise specified below.
Your prompt reply to my request is greatly appreciated.

According to state and Federal Law, this form must be signed in order to process the release of patient information if such information exists in your chart. Vision Center of Texas charges a fee of $10.00 for transfers to another doctor's office.

| | |
|---|---|
| **Patinet Name:** *(Please Print)* | **Date of Birth:** |
| **Patient Signature:** | **Date:** |

### Acknowledgement of Review of Notice of Privacy Practices

My signature above indicates that I have reviewed this office's Notice of Privacy Practice, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document at my request.