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Medical Records Release

(Name of Patient)

(Birthdate)

(Street Address)

(City, State, ZIP Code)

Authorizes:

Release of Records to:

DR LUU

(Name of Physician)

(Name of Physician)
LITTLE EYES PEDIATRIC EYE CARE & ADULT
STRABISMUS

(Name of Health Care Facility)

(Name of Health Care Facility)

3801 W 15TH ST, STE A110

(Street Address)

(Street Address)

PLANO TX 75075

(City, State, ZIP Code)

(City, State, ZIP Code)

Phone Number

Fax Number

Information to be Released:

- | | | |
|---|--|--|
| <input type="checkbox"/> All Clinic Records | <input type="checkbox"/> Visual Fields | <input type="checkbox"/> Lab Reports |
| <input type="checkbox"/> Office Notes | <input type="checkbox"/> X-Ray Reports | <input type="checkbox"/> Other (Specify) |
| <input type="checkbox"/> 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:

- | | | |
|---|---|-------------------------------------|
| <input type="checkbox"/> Mental health | <input type="checkbox"/> AIDS test results | <input type="checkbox"/> Drug abuse |
| <input type="checkbox"/> Developmental disabilities | <input type="checkbox"/> Aids-related disease diagnosis | <input type="checkbox"/> Other |
| <input type="checkbox"/> Alcoholism | | |

Purpose or need for disclosure: (check applicable categories)

- | | | |
|--|---|--|
| <input type="checkbox"/> Further medical care | <input type="checkbox"/> Payment of insurance claim | <input type="checkbox"/> Legal investigation |
| <input type="checkbox"/> Application for insurance | <input type="checkbox"/> Vocational rehabilitation evaluation | <input type="checkbox"/> Personal |
| <input type="checkbox"/> Disability determination | | <input type="checkbox"/> Other |

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 one (1) year)

I authorize release of my medical records in accordance with the specifications listed above. I understand written notice is necessary to cancel this request.

Signature of Patient _____ **Date** _____
(If signed by person other than patient, state relationship and authorization to do so)

(Authorized signature)

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

Legal Authority: ☐ Legal ☐ Legal guardian ☐ Next of kin of deceased