TEXARKANA
EYE ASSOCIATES

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone No. _____

City: _____ State: _____ Zip: _____

I hereby authorize Texarkana Eye Associates to disclose medical record information and/or protected health information of the patient listed above to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No. _____ Fax No. _____

Disclose the following protected health information:

- Glasses and/or Contact Lens Prescription
- Last Exam
- Entire Medical Record ($15.00)
- Other: _____

_____

_____ Date: _____
Signature of Patient

_____ Date: _____
Signature of Parent and/or Guarding (if minor)

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED

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