Eyes of Texas Vision Care
8001 Burnet Road
Dr. Fern Yee, Optometrist
Austin, TX 512-454-5117
Fax: 512-450-1496

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name: ________________________________ Date of Birth: _________________

INFORMATIONTO BE RELEASED **BY:**	INFORMATION TO BE RELEASED **TO:**
_______________________________________ Organization/Name _______________________________________ Address _______________________________________ Phone Fax	Eyes of Texas Vision Care____________________ Organization/Name 8001 Burnet Road Austin, TX 78757__________ Address 512-454-5117_______________512-450-1496__ Phone Fax

TYPE OF MEDICAL INFORMATION REQUESTED:

□ Communication between the above named □ Complete chart notes
□ My health information only for the following date(s): ____
□ My health information relating only to the following treatment or condition: ______________________
□ Other: ____

I authorize the professional office of my doctor named above to **release health information or receive health** information identifying me or my child [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

It is completely your decision to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization form.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes.
Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Signature: ____ **Date:** _________________