321 S. Henderson St., Fort Worth, TX 76104 • 105 River Oaks Dr., Southlake, TX 76092 • 1106 Alexis Ct., Mansfield, TX 76063

Pediatric Eye Specialists

# Medical Records Release

**I hereby authorize** *(physician or facility):* _____
**to release information from the medical record of:**

Patient Name: Birth Date:

**INFORMATION MAY BE RELEASED TO**

NAME: Pediatric Eye Specialists, LLP
ADDRESS: 321 S. Henderson Street
Fort Worth, Texas 76104

TELEPHONE: 817-529-9949
FAX: 817-529-9943

The purpose for the release of medical records is as follows:

**INFORMATION OR MEDICAL RECORDS AUTHORIZED FOR RELEASE**

- ☐ History and Physical
- ☐ Discharge Summary
- ☐ **Other (Please List)**
- ☐ Diagnostic Testing and Release
- ☐ Operative Record and Pathology
- ☐ ALL

**LIST DATES OF ADMISSION AND DISCHARGE OR TREATMENT**

I understand that medical records are confidential and cannot be disclosed without my written authorization, except otherwise provided for by law.

I also understand that records pertaining to the diagnosis and/or treatment of HIV testing, AIDS, psychiatric illness, alcohol or chemical abuse and dependency will not be released unless I have given my specific consent to release this information as indicated above.

I also understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it.

I understand that a photocopy or facsimile of this authorization is valid as the original.

Parent or Adult Guardian Signature Date

Relationship to Patient

ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT(S) IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSE.