

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Children's Eye Center to release information from the medical records of:

_____ / _____ / _____
(Patient Name) (Date of Birth)

To / From:

Phone Number: _____

Fax Number: _____

To / From:

Children's Eye Center
Lonn Bradley Lockhart, M.D.
A. Melinda Rainey, M.D.
1912 West 35th Street • Austin, Texas 78703
Phone: (512) 458-1922 Fax: (512) 458-8362

I waive the privilege of confidentiality of the following information; this is also the information to be released:

- | | |
|---|--|
| <input type="checkbox"/> doctors notes | <input type="checkbox"/> operative notes |
| <input type="checkbox"/> hospital summaries | <input type="checkbox"/> all records (NOT including financial) |
| <input type="checkbox"/> radiology reports | <input type="checkbox"/> all records (including financial) |
| <input type="checkbox"/> other: _____ | |

The purpose for this release of information:

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> continue patient's care | <input type="checkbox"/> insurance |
| <input type="checkbox"/> eye report for school or agency | <input type="checkbox"/> other: _____ |

I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it. In any event, this authorization expires automatically in one (1) year from the date of signature or as otherwise specified.

Signature: _____ Date: _____

If you are not the patient, what is your relationship to the patient? _____

Witness: _____

PROHIBITION ON REDISCLOSURE: This information is being disclosed to you from confidential records. You are prohibited from making any further disclosure of this information except with the specific written consent of the person to whom it pertains and the facility from which the information originates.