Pediatric Ophthalmology, P.A. and the Center for Adult Strabismus

CYNTHIA L. BEAUCHAMP, M.D.
LORI DAO, M.D.

Fees for records $25.00.
Please enclose payment.

ALAN D. DAVIS, M.D.
JOHN T. TONG, M.D., F.A.C.S.
ROBERT D. GROSS, M.D., F.A.A.P.

Medical Records Release

(Name of Patient) _____ (Birthdate) _____

(Street Address) _____ (City, State, Zip Code) _____

Authorizes:

(Name of Physician) _____

(Name of Health Care Facility) _____

(Street Address) _____

(City, State, Zip Code) _____

Release of Records to:

(Name of Physician) _____

(Name of Health Care Facility) _____

(Street Address) _____

(City, State, Zip Code) _____

Information to be Released:

- ☐ All Clinic Records
- ☐ Office Notes
- ☐ Photographs
- ☐ Visual Fields
- ☐ X-Ray Reports
- ☐ Lab Reports
- ☐ Other (Specify)

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:

- ☐ Mental health
- ☐ Developmental disabilities
- ☐ Alcoholism
- ☐ AIDS test results
- ☐ AIDS-released disease diagnosis
- ☐ Drug abuse
- ☐ Other

Purpose or need for disclosure: (check applicable categories)

- ☐ Further medical care
- ☐ Application for insurance
- ☐ Disability determination
- ☐ Payment of insurance claim
- ☐ Vocational rehabilitation evaluation
- ☐ Other (Specify)
- ☐ Legal investigation
- ☐ Personal

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 (1) year)

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

Signature of Patient/Parent: _____ Date: _____

(if signed by person other than patient, state relationship and authorization to do so)

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

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

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