Authorization to Disclose Health Information

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name: _____ Phone # _____

Date of Birth: _____ Social Security # _____

I authorize North Dallas Eye Associates

1850 Lakepointe Dr. **Suite 200** **Lewisville, TX 75057** **PH (972) 436-5040** **FX (877) 715-3317**	**6020 W. Parker Rd.** **Suite 250** **Plano, TX 75093** **PH (972) 378-5117** **FX (877) 715-3317**	**5575 Warren Pkwy.** **Suite 308** **Frisco, TX 75034** **PH (214) 618-3937** **FX (877) 715-3317**	**2817 S. Mayhill Rd.** **Suite 110** **Denton, TX 76208** **PH (940) 898-1512** **FX (877) 715-3317**	**2560 Central Park Ave.** **Suite 300** **Flower Mound, TX 75028** **PH (972) 355-0194** **FX (877) 715-3317**

Receive Medical Information from: **OR** **Send Medical Information to:**

_____ _____

_____ _____

_____ _____

Phone # _____ Phone # _____

Fax # _____ Fax # _____

For the reason of: _____

Please release the following:

- ☐ Problem List / Exams
- ☐ Progress Notes
- ☐ History / Physical Exam
- ☐ List of Medication / Allergies
- ☐ Visual Field Test
- ☐ X-Ray / Imaging Reports _____
- ☐ Laboratory Results _____
- ☐ Other Diagnostic Reports _____
- ☐ Other (specify) _____
- ☐ All of the Above

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in **CFR 1064.542**. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any further questions about disclosure of my health information, I can write to the Privacy Officer at **1850 Lakepointe Dr. Ste 200 Lewisville, TX 75057.**

_____ _____ _____

Signature of Patient or Legal Representative | Relationship to Patient (*If Legal Representative*) | Date