Cornea Associates of Texas

Celebrating 30 Years
www.corneatexas.com

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PATIENT AUTHORIZATION TO RELEASE PROTECTED INFORMATION

I authorize Cornea Associates of Texas to release protected health information to the individual(s) listed below for the purpose of assisting with my care and/or payment.

To Whom Medical Records Release To

Address **City** **State** **ZIP**

Phone # **Fax # (If records need to be fax/doctor only)**

Date of Last Office Visit ****If last seen 3 yrs ago or longer, was patient seen under a different last name? Yes ☐ No ☐ If checked yes, please print full previous name*_____

Description of the information to be used or disclosed:

-Patient's demographic information
-Patient's medical information
-Patient's billing information

I understand that this authorization will be in effect during the time period I am a patient at Cornea Associates of Texas.

I further understand that this authorization is voluntary and that my health care and the payment of my health care will not be affected if I do sign this form.

I further understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

I further understand that I may revoke this authorization at any time by notifying *Cornea Associates of Texas* in writing at 10740 North Central Expressway, *Suite 350, Dallas, Texas 75231.* I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Signature of Patient or Patient's Representative Today's Date

Printed name of Patient Patient Date of birth

Relationship to Patient or Legal Authority Patient Phone Number