

PLASTIC EYE SURGERY ASSOCIATES, PLLC
AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

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AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

I _____, date of birth _____ hereby
request my medical records be released to:

Name or person or organization to receive records

Address/City/State/Zip Code

Phone: _____ Fax: _____

This authorization applies to all of the reports checked:

- | | |
|-----------------------|----------------------------------|
| Medical History | Operative Reports |
| Lab/Path Reports | Health Assessment Questionnaires |
| Clinical Office Notes | Photographs |

Purpose of disclosure: (check all that apply)

- | | |
|--------------|-------------|
| Medical Care | Attorney |
| Insurance | Other _____ |

This authorization is valid for 1 year from the date of signature.

Prohibition of Redisclosure

Federal rules prohibit any further disclosure of this information unless disclosure is expressly permitted by written consent of the person to whom it pertains.

Signature Date
The patient may revoke this authorization in writing at any time

Patient's Printed Name

Note: Fee of \$25.00 may apply

Return Completed Form To: Medical Records Dept. Fax 713/807-0630