

Rockwall Eye Associates
Medical Release of Information Form

Patient Name _____ **Date of Birth** _____

Social Security # _____ Previous Name _____

I Request and Authorize Rockwall Eye Associates/Dr. Edward Hurst/Dr. Kate Lee

To Release the Medical Record of the above named Patient to:

Physician/Patient _____

Address, City, State, Zip _____

Phone _____ Fax _____

X _____ Date _____
Signature of Patient or Authorized Representative

X _____
Relationship or Status if signed by anyone other than the Patient (Parent, Child,
Legal Guardian, Personal Representative, Etc.)

Unless otherwise revoked this authorization will expire six months from the date signed. I understand that authorizing the disclosure of this health information is voluntary. 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 confidentiality rules.