Rockwall Eye Associates

Medical Release of Information Form

Patient Name______________________________ **Date of Birth**_______________

Social Security #____________________________Previous Name______________

I Request and Authorize____

(Name of Physician and Clinic/Practice)

Address, City, State, Zip____

Phone______________________________ Fax______________________________

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

ROCKWALL EYE ASSOCIATES
2380 SOUTH GOLIAD, SUITE 100
ROCKWALL, TX 75032

PHONE 972-771-2020 FAX 972-722-4858

Reason for Release: Medical Eye Exam

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.