1602 Lancaster Dr. Ste.102
Grapevine, TX 76051
Phone: (817) 885-7878
Fax: (817) 885-7444

Glaucoma Consultants of Texas

Varun Reddy, M.D.
Sonal Patel, O.D.

1650 W. Rosedale, Ste.201
Fort Worth, TX 76104
Phone: (817) 885-7878
Fax: (817) 885-7444

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____
Address: _____
City State Zip Code
Telephone: _____

I authorize the release of records TO / FROM: **To be released TO / FROM:**

Glaucoma Consultants of Texas
1602 Lancaster Dr. Ste. 102
Grapevine, TX 76051
Office: 817-885-7878
Fax: 817-885-7444

Name _____
Address _____
City/State/Zip _____
Phone#_____ Fax# _____

Please check the type of information to be released:

☐ Most Recent Chart Note (Complimentary) ☐ Most Recent Visual Field (Complimentary)

☐ Medical Records: From (date)_____ To (date)_____ $25 minimum processing fee

☐ Demographic Sheet ☐ Billing Records

☐ Other (Specify)_____

I am authorizing the release of my Protected Health Information for the following purpose:

☐ Coordination of Care ☐ Transfer of Care (Specify Reason) _____

☐ Legal (Specify)_____ ☐ Other (Specify)_____

The Texas Medical Board (TMB) rules set the allowable charge for copies under Texas law. For paper copies, the charge is $25 for the first 20 pages, and 50 cents for each page thereafter. I understand there will be a $25 minimum processing fee. I understand I may opt for a copy of my most recent chart note/visual field at no charge. I understand that Glaucoma Consultants of Texas will process my request within 15 business days.

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

_____ _____
Patient/Legal Representative Signature **Date**

_____
Description of Relationship if not Patient