Eye Care… You'll see.
eye associates
Of Central Texas

Authorization for Disclosure of Confidential Information

Patient's Name: _____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____/_____/_____ SS# _____/_____/_____

Authorizes (please circle): EYE ASSOCIATES OF CENTRAL TEXAS

Thomas L. Hendrix, M.D. Patricia B. Dearman, M.D. W. Thomas Kittleman, M.D.

Kimberly T. Golde, M.D. Lena A. Dixit, M.D.

To release the following:

_____ History, Exam, Diagnoses, Plans & Progress Notes

_____ Visual Fields

_____ Photos

_____ Other (Please specify) _____

To: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone: _____ Fax: _____

This authorization shall be valid for 90 days from the date of signature. The patient can revoke this authorization at any time prior to the expiration date.

The patient agrees that a photocopy of this authorization may be considered valid.

_____ Yes _____ No

Patient's Signature: _____

Date: _____/_____/_____

Mail or Fax this completed form to the office where you are a patient:

2120 Round Rock Avenue, Suite 100
Round Rock, Tx 78681
(512) 244-1991
Fax: (512) 244-1786

603 Mallard Lane
Taylor, Tx 76574
(512) 352-7664
Fax (512) 365-5237

www.eyeassociatestexas.com