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 Doctor: _____
Doctor's Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

To release the following information to (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 Dixit, M.D.

To release the following:

_____ History, Exam, Diagnoses, Plans & Progress Notes
_____ Visual Fields
_____ Photos
_____ Other (Please specify) _____

This authorization covers patient from _____ to _____

Purpose of Disclosure:

_____Medical Care _____Attorney
_____Insurance _____Other _____

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