Eye Associates of Central Texas

Authorization for Disclosure of Confidential Information

Patient Information

Name | Home Phone | Cell Phone

Address | City | State | Zip

Date of Birth (MM/DD/YYYY)

Authorizes Eye Associates of Central Texas (check one):

☐ W. Thomas Kittleman, MD ☐ Kimberly T. Golde, MD ☐ Lena A. Dixit, MD ☐ Ravi H. Patel, MD

to release the following information (check all that apply):

☐ History, Exam, Diagnoses, Plans & Progress Notes ☐ Visual Fields ☐ Photos

☐ Other (Please specify) _____

to the following:

Physician Name | Phone | Fax

Address | City | State | Zip

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

☐ Yes ☐ No

X

Patient Signature | Date (MM/DD/YYYY)

Mail or fax this completed form to your physician's office.

This authorization shall be valid for 90 days from the date of signature. Patient may revoke this authorization at any time.

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