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)

Authorized Physician to Release Patient's Information

Physician Name | Phone | Fax

Address | City | State | Zip

To release the following information to (check box):

Eye Associates of Central Texas

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

Information to be released (check all that apply):

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

☐ Other (Please specify) _____

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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e: info@eyeassociatestexas.com

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O: 512.244.1991 F: 512.244.1786

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603 Mallard Lane, Taylor, Texas 76574
O: 512.352.7664 TF: 800.447.2694
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