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

- ☐ Kimberly T. Golde, MD
- ☐ Lena A. Dixit, MD
- ☐ Ravi H. Patel, MD
- ☐ Oliver G. Fisher, MD, MS
- ☐ W. Thomas Kittleman, MD
- ☐ Jason Stone, OD

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.

eyeassociatestexas.com
E: info@eyeassociatestexas.com
O: 512.244.1991
F: 512.244.1786

Round Rock
2120 Round Rock Ave
Suite 100
Round Rock, Texas 78681

Austin
3807 Spicewood Springs Rd
Suite 101
Austin, Texas 78759

Taylor
603 Mallard Lane
Taylor, Texas 76574