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
- ☐ Jason Stone, OD
- ☐ Hiren Patel, 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.

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

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2120 Round Rock Avenue, Suite 100
Round Rock, TX 78681

Georgetown
3618 Williams Drive, Suite 101
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Taylor
603 Mallard Lane
Taylor, TX 76574