PLASTIC EYE SURGERY ASSOCIATES, PLLC
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Telephone (713) 795-0705 Fax (713) 807-0630
Toll (877) 958-2020

AUTHORIZATION TO RELEASE HEALTH INFORMATION

INFORMATION REGARDING PATIENT WHO IS REQUESTING AUTHORIZATION:
Full Name: _____
Other Name Used: _____Date of Birth: _____
Address: _____
City: _____State:_____ Zip Code: _____
Phone: (_____) _____

INFORMATION REGARDING PERSON OR ENTITY AUTHORIZED TO RECEIVE INFORMATION:
Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: (_____) _____ Fax: (_____) _____

SPECIFIC INFORMATION TO BE DISCLOSED:
____ Medical Record from (insert date) _____ to (insert date) _____

____ Entire Medical Record, including patient histories, office notes, test results, radiology reports, pathology reports, referrals, consults, and records received from other health care providers.

____ Partial Medical Record (please check the items you would like disclosed)

_____ Clinical Office Notes	_____ Demographic Information
_____ Medical History	_____ Insurance Information
_____ Lab/Path Reports	_____ Photographs (black & white)
_____ Operative Reports	_____ Photographs (color)

PURPOSE OF DISCLOSURE: (Choose all that apply)
This is important as it indicates whether or not a legal affidavit of complete and accurate disclosure must accompany the record.

____ Treatment/Medical Care
____ Personal Use
____ Billing or Claims
____ Insurance
____ Legal Purposes
____ Disability Determination
____ School
____ Employment
____ Other (Please specify) _____

AUTHORIZATION TO RELEASE HEALTH INFORMATION (continued)

THIS AUTHORIZATION IS VALID FOR 1 (ONE) YEAR FROM THE DATE OF THE SIGNATURE

Signature forgery (even with verbal permission from patient) by spouse, family member, friend, or representative without legal power of attorney is an actionable criminal offense.

1. **VOLUNTARY AUTHORIZATION:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits will not be conditioned upon my signing of this authorization form.

2. **RIGHT TO REVOKE:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

3. **SIGNATURE AUTHORIZATION:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop the disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:

Patient/Legal Representative: _____ Date: _____

If Legal Representative, relationship to Patient: _____

Witness (optional): _____ Date: _____

NOTE: THE FOLLOWING **FEES** APPLY (Fees have been determined by the Texas Medical Practices Act by the Texas Medical Board).

1. Clinical Record only: 6 (six) office visits or less-no charge
2. Complete Medical Record: $25.00 for the first 20 pages; $0.50 each additional page
3. Color Photos: $1.00 per photo
4. Black & White Photos: $0.50 per photo
5. Postage Rates: (Postage rates are **subject to change**. Postage rates are based on current rates as of November 13, 2014.)
   $0.98 up to 4 pages; $1.19 (5-10 pages); $1.40 (11-17 pages); $1.61 (18-23 pages);
   $1.82 (24-29 pages); $2.03 (30-36 pages); $2.24 (37-42 pages); $2.45 (43-49 pages)
   $2.66 (50-55 pages); $2.87 (56-61 pages); $3.08 (62-67 pages); $3.29 (68-74 pages)
   $3.50 (75-79 pages)
   Any record above 79 pages will be based on zip code.
6. Legal affidavit of complete and accurate disclosure: $30.00