Cosmetic and Reconstructive
Surgery of the Eye Region
PLASTIC EYE SURGERY ASSOCIATES, PLLC
www.plasticeyesurgery.com

James R. Patrinely, MD, FACS
Charles N.S. Soparkar, MD, PhD, FACS

Authorization for Release of Healthcare Information

I hearby authorize the transfer/receipt of the following healthcare information:

Patient Name:
DOB:

To: Charles N.S. Soparkar, MD, PhD
3730 Kirby Drive, Suite 900
Houston, TX 77098

Phone: (713) 795-0705
Fax: (713) 807-0630
Email: info@pesahouston.com

From: ____

____

____

Phone: ____

Fax: ____

__ Progress Notes __ Consultation Reports __ Operative Reports __ Complete Record

__ Laboratory Studies __ Neuroimaging Studies

Purpose of Disclosure: X Continuing Patient Care

I understand that this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. The revocation must be in writing and delivered to Plastic Eye Surgery Associates, PLLC. It is further understood that the information released is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization, or person. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and is no longer protected.

THIS CONSENT WILL EXPIRE 180 DAYS AFTER DATE OF SIGNATURE

____
(Signature of Patient) (Date)

____
(Signature of Patient's Representative) (Date)

____
(Witness) (Date)

____
(Relationship to Patient)