



Richard L. Scott, O. D. Grant W. Gibson, O. D. Misti D. Gibson, O. D.

Authorization for Release of Identifying Health Information

Patient Name: _____ Date of Birth: _____

Authorizes/Release Records to:

Authorizes/Release Records to:

Physician: _____

Physician: Klein Eyecare

Phone Number: _____

Phone Number: (281) 370-2020

Fax Number: _____

Fax Number: (281) 251-2705

Information to be released:

_____ All Records

_____ Glasses Rx

_____ Photographs

_____ Contact Lens Rx

_____ Visual Fields

_____ Scanning Laser Ophthalmoscopy
(OCT/ HRT/ RTA results)

Purpose or need for disclosure:

It is completely your decision whether or not to sign this form. We cannot refuse to treat you if you choose not to sign this authorization. If you do choose to sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. I authorize the release of health information identifying me and including, if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services.

I authorize release of my medical records in accordance with the specifications listed above. I understand written notice is necessary to cancel this request.

Date of Signature: _____ **Date of Expiration:** _____

Signature of Patient or other authorized person: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign the form:

Relationship : _____ Printed Name: _____

Source of Authority: _____