CORNEA CONSULTANTS
of Texas

RELEASE OF MEDICAL INFORMATION

I hereby authorize Cornea Consultants of Texas to release the following information from the health records of:

Patient Name: _____ _____

Date of Birth: _____ **Social Security Number:** _____

Covering the period of treatment from: _____**to:** _____

Information be released:

- Narrative Summaries
- Medical records including copies of diagnostic testing
- Complete medical records
- Financial and billing records

Other: _____

Information is to be released to: _____
Address:_____
Fax: (_____)_____ **Attention:**_____

Purpose of Disclosure: **Patient Referral, Continuity of 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 content. If, revocation is not received, authorization will be considered valid for a period of time not to exceed 180 days.

List date, event, or condition upon which this consent expires: _____

The facility, it's employees and officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. I understand the information released could contain references of HIV antibody (AIDS) testing.

_____ _____
Patient Name Date

_____
Patient's Signature (or Authorized Representative/Guardian)

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