GLAUCOMA CENTER OF TEXAS

Arvind Neelakantan MD FRCOphth

Azra Idrizovic DO

RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

I hereby authorize release of my health information from:

_____

(Physician Office/Name)

Information to be released:

- Complete Medical Records
- Chart dictations, Procedure Notes
- Imaging and ancillary testing records including OCT, Visual Fields, Optic disc photographs, IOL calculations, Corneal topography

Other: _____

Please send this information as soon as possible to:

Glaucoma Center of Texas

FAX: (972) 499 - 1206

RIGHTS OF THE PATIENT:

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address above. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient. ***Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPPA).*** I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

_____ _____

Signature of Patient or Patient's Representative Date

_____ _____

Printed Name of Patient or Patient's Representative Relationship to Patient