GLAUCOMA CENTER
OF TEXAS

Patient Authorization To Release Protected Health Information

I authorize Glaucoma Center of Texas to release protected health information to the individual (s) listed below for the purpose of assisting with my care and/or payment.

Name	Relationship to Patient	Phone Number
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Description of the information to be used or disclosed:

- Patient's demographic information
- Patient's medical information
- Patient's billing information

I understand that this authorization will be in effect during the time period that I am a patient at Glaucoma Center of Texas.

I further understand that this authorization is voluntary and that my health care and the payment of my health care will not be affected if I do not sign this form.

I further understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

I further understand that I may revoke this authorization at any time by notifying *Glaucoma Center of Texas* in writing at *9600 N. Central Expressway, Suite 300, Dallas, Texas 75231.* I also understand that the written revocation must be signed and dated with a date that is later that the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation

_____ _____

Signature of Patient or Patient's Representative | Date

_____ _____

Printed Name of Patient or Patient's Representative | Relationship to Patient or Legal Authority