Lakeway Eye Center

900 RR 620 South, Suite B112
Lakeway, TX 78734
512-263-0225
Fax 512-263-8590

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name _____DOB_____
Address _____
Phone Number _____

I authorize _____ to release my health information to: Lakeway Eye Center / Wally El-Hitamy, O.D.

Information to be released:

____Copy of complete records

____Copy of spectacle RX

____Copy of contact lens RX

Comments:

It is completely your decision to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you 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 this authorization. If you want to revoke your authorization, send us a written note telling us that your authorization is revoked. Send this note to the person listed at the top of this form.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Signature _____ Date _____