INCOMINGING MEDICAL RECORD REQUEST

OPHTHALMOLOGY ASSOCIATES
It's a beautiful world. See it well.

1201 Summit Avenue, Fort Worth, Texas 76102
PHONE: 817-332-2020 **FAX: 817-810-0791**

Federal rules prohibit any disclosure of this information unless disclosure is expressly permitted by the written consent of the person to whom it pertains.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Printed Name: ____

Address: ____

DOB ______________________ **Phone:** ____________________________ **Account#** __________________

City ____ **State** ___________________ **Zip** ___________

MY RECORDS ARE CURRENTLY WITH:

Dr. Name ____

Clinic Name ____

Address ____

Phone ____ **Fax** ________________________________

City ____ **State** _________________ **Zip** ____________

PLEASE SEND MY RECORDS TO:

I hereby request that copies of these records for dates ____________________ through ___________________ ARE RELEASED AND SENT TO:

Name of OA Physician ____

OPHTHALMOLOGY ASSOCIATES
1201 SUMMIT AVENUE
FORT WORTH, TEXAS 76102
817-332-2020 FAX - 817-810-0791

Please MAIL OR EMAIL records if page count is over 20 pages!
CHARTROOM@OAFW2020.COM

This authorization is valid for ___________ **days** from date of signature below and may be revoked in writing at any time. If the date is not specific, it will automatically expire in 90 days.

Purpose of Release: ___Medical Care ___Insurance Claim ___Legal ___Disability
___FMLA ___Moving ___Wanted a closer place ___Insurance Change

Other ____

The following records should **NOT BE RELEASED** ____

____ ______________________________
Signature of Patient or Patient's Authorized Representative **Date**

____ ______________________________
Printed name of Patient or Patient's Authorized Representative **Relationship**