OUTGOING 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**

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

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

Patient's Printed Name: _____

Address: _____

DOB _____ **Phone:** _____ **Acct#** _____

City _____ **State** _____ **Zip** _____

Email address: _____

MY RECORDS ARE WITH:

OA PHYSICIAN NAME: _____

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

Approved by:
_____

MY RECORDS ARE TO BE SENT TO: (for sending to another doctor's office or to patient)

I hereby request that copies of my records for dates _____ **through** _____
ARE TO BE RELEASED AND SENT TO :

Name _____

Clinic Name (optional) _____

Address _____

Phone _____ **Fax** _____

City _____ **State** _____ **Zip** _____

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** _____

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. I understand that Ophthalmology Associates may charge a fee for the costs of these records in accordance with Texas guidelines.

_____ _____
Signature of Patient or Patient's Authorized Representative **Date**

_____ _____
Printed name of Patient or Patient's Authorized Representative **Relationship**