



Authorization To RELEASE Health Information

1441 Woodstead Ct. Ste 110
The Woodlands, TX 77380
(281) 944-EYES (3937)
clinic@woodlandslowvision.com

Patient Information

Name:
Date of Birth:
Address:
City: State: Zip Code:
Telephone:
Email:

Information To Be RELEASED

I authorize The Woodlands Low Vision Clinic to SEND records TO:

Physician Name:
Address:
City: State: Zip Code:
Telephone:
Fax:
Email:

Method of Delivery:

- Any of the following: Mail, Fax, Pick-up, Secure Email, Verbal
Specify:

Effective Time Period for Authorization (optional):

The authorization is valid until the earlier of: the authorization is withdrawn, the age of majority, the patient's death, or the following specified date (optional):

Information RELEASED:

- All health records from the past 12 months OR
Records from to OR
All available records OR
Other specified medical information (as indicated here):

**Purpose of Disclosure:**

- Continued medical care
- Patient request
- S.S. Disability Determination
- Other: \_\_\_\_\_

*Unless otherwise specified, records may exclude HIV testing, mental health records, genetic information, and chemical dependency testing.*

**SENDER of Information**

I am authorizing transmission of this information **from:**  
 Entity: The Woodlands Low Vision Clinic  
 Address: 1441 Woodstead Ct #110  
 City: The Woodlands State: TX Zip Code: 77380  
 Phone/Fax: **Secure Fax (281) 721-4433**  
 Email: clinic@woodlandslowvision.com

**Consent and Signature**

- By signing below, I understand and agree to the following:
1. *I authorize the release of protected health information as indicated above to the approved listed party.*
  2. *I may revoke this authorization at any time by sending a written revocation. I understand that the revocation will not apply to any health information previously disclosed in reliance of this authorization.*
  3. *Any treatment, payment, or eligibility for services or benefits will not be affected if I do not sign this authorization.*
  4. *Any information disclosed by this authorization to any person/organization not a healthcare provider, business associate of a healthcare provider or health plan covered by federal and state privacy regulations could be redisclosed by the recipient and no longer protected by those regulations.*
  5. *I am entitled to receive a copy of this authorization.*
  6. *I understand that requests for copies of records are subject to fees in accordance with federal and Texas regulations.*

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**Signature of Patient/Guardian/Legal Representative** **Date**

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**Printed Name** **Relationship, if not patient**