THE WOODLANDS LOW VISION CLINIC

Authorization To REQUEST 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 Requested

I authorize The Woodlands Low Vision Clinic to **RECEIVE** records ***FROM:***

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The authorization is valid until the earlier of: the authorization is withdrawn, the age of majority, the patient's death, or the following specified date (optional): _____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

- ☐ 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 ☐ S.S. Disability Determination
☐ Patient request ☐ Other:_____

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

RECIPIENT of Information

I am authorizing transmission of this information ***to:***
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.*

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

Printed Name **Relationship, if not patient**