RICHARDSON EYE ASSOCIATES

Family Eye Care
Contact Lenses
Fashion Eyewear

660 West Campbell Road, Suite 102
Richardson, Texas 75080
(972) 231-3439

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____

I hereby authorize RICHARDSON EYE ASSOCIATES to release my personal health information for the purpose of obtaining my vision or medical insurance reimbursement benefits under my insurance policy. I authorize the release of any identifying or medical information needed to determine these benefits.

I authorize the release of any personal identifying or medical informatin for the purpose of continuing my medical care.

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

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Patient Signature: _____ Date: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

Relationship to Patient: _____ Print Name: _____

Source of Authority: _____