

North Texas Center for Sight
2220 Emery Street Suite 100
Denton, TX 76201
(940) 243-2020
Fax (940) 382-9944

Authorization for Release of Protected Health Information

I, _____ DOB: _____ hereby authorize

_____ Phone #: _____

Fax #: _____ to release the information identified in this authorization form.

From the health records of: _____
(Name/ DOB/ SS#)

For the purpose of: _____

My authorization only extends to those documents marked below:

- Chart summary/ Most recent chart notes
- Lab work
- Visual Fields
- Other: _____

Right to Revoke Authorization: Except to the extent that action has already been taken in reliance on this authorization, the authorization may be revoked at any time by submitting a written notice to North Texas Center for Sight, ATTN: Medical Records, 2220 Emery Street, Suite 100, Denton, Texas 76201

Records Request Processing Fee: Processing fee of \$25.00 for the first twenty pages, then \$0.50 for every page requested thereafter. Payment is required before North Texas Center for Sight will begin to process my request.

Signature: _____ Date: _____