Authorization to Release Medical Records

I _____, hereby request my records to be released to:

Greater Houston Eye Consultants
6330 West Loop South, Ste: 100
Bellaire, TX 77401

Bellaire Office-	Phone: 713-661-6500	Fax: 713-661-6527
Fallbrook Office-	Phone: 281-454-2056	Fax: 281-454-2091

This authorization applies to all of the following: (last 3yrs only)

_____ History
_____ Progress Notes
_____ Operative Notes
_____ Diagnostic Notes

Purpose of disclosure:

_____ Medical Care
_____ Insurance
_____ Attorney (fee will apply)
_____ Other _____

_____
Print Patient Name and Date of Birth

_____ _____
Signature of Patient or Guardian Date