GREATER HOUSTON
EYE CONSULTANTS

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 fax: 713-661-6527
Fallbrook: 281-477-7100
Katy: 281-347-6505
Humble: 281-454-2091
Clearlake: 281-922-1580

This authorization applies to all of the following:

___ History
___ Progress Notes
___ Operative Notes
___ Diagnostic Test

Purpose of disclosure:

___ Medical care
___ Insurance
___ Attorney (fee applies)
___ Other _____

_____
Patient Name & Date of birth

_____
Signature of patient or guardian Date: