Authorization to Disclose Private Healthcare Information

I, _____, do authorize Texas Vision & Laser Center to release information including the diagnosis, records; examination rendered to me, and claims information. Information may be release to:

[ ] My Spouse, _____

[ ] On my answering machine, _____

[ ] My child, _____

[ ] My friend, _____

[ ] Other, _____

_____ _____

Patient Signature Date of Birth

_____

Witness Signature

_____

Date