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MCKINNEY, TX 75071

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FRISCO, TX 75034

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JASON D. BULLAJIAN, MD, FACS

KATIE N. STARKS, MD, MS

Authorization for Medical Records Release

Patient Information:

Patient Name: _____

Date of Birth: _____ SSN# _____

Address: _____ City: _____ State: _____

Phone: _____ Email: _____

<p>This information is to be released TO:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>City _____ State _____ Zip _____</p> <p>Phone _____ Fax _____</p>	<p>This information is to be released FROM:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>City _____ State _____ Zip _____</p> <p>Phone _____ Fax _____</p>
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Information being requested:

Complete Record

Records of care from the following dates: _____ to _____

<p>State statute requires special permission to release otherwise privileged information. Please check applicable categories for release of records.</p> <p><input type="checkbox"/> Mental Health <input type="checkbox"/> Alcoholism</p> <p><input type="checkbox"/> Developmental disabilities <input type="checkbox"/> AIDS test results</p> <p><input type="checkbox"/> AIDS related diagnosis <input type="checkbox"/> Drug abuse</p>	<p>Purpose or need for disclosure:</p> <p><input type="checkbox"/> Further medical care <input type="checkbox"/> Application for insurance</p> <p><input type="checkbox"/> Payment of ins claim <input type="checkbox"/> Disability determination</p> <p><input type="checkbox"/> Vocational rehab eval <input type="checkbox"/> Personal</p> <p><input type="checkbox"/> Legal investigation <input type="checkbox"/> Other</p>
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I hereby authorize the information indicated on this form to be released from and to the indicated parties. I understand that this authorization shall be valid for one (1) year unless otherwise stated on this form or through written notice to medical records. (Alternate date if not one (1) year _____). I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information that has been written in the record. I will not hold the Texas Vision & Laser Center liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

Patient Signature: _____ Date: _____

Signature of Legal Representative: _____ Date: _____

Relationship: _____ Witness: _____