4701 MEDICAL CENTER DR, #1A
MCKINNEY, TX 75069

8380 WARREN PARKWAY, #101
FRISCO, TX 75034

PHONE: 972-548-2015
FAX: 972-548-2014

JASON D. BULLAJIAN, MD, FACS

Authorization for Medical Records Release

Patient Information:

Patient Name: ____

Date of Birth: ___________________________ SSN# _____________________________

Address: ______________________________ City: ____________________ State: __________

Phone: _______________________________ Email: ______________________________

This information is to be released **TO**:	This information is to be released **FROM**:
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
City State Zip	City State Zip
__________________ __________________	__________________ __________________
Phone Fax	Phone Fax

Information being requested:

- ☐ Complete Record
- ☐ Records of care from the following dates: _______________ to _______________

State statute requires special permission to release otherwise privileged information. Please check applicable categories for release of records.

- ☐ Mental Health
- ☐ Developmental disabilities
- ☐ AIDS related diagnosis
- ☐ Alcoholism
- ☐ AIDS test results
- ☐ Drug abuse

Purpose or need for disclosure:

- ☐ Further medical care
- ☐ Payment of ins claim
- ☐ Vocational rehab eval
- ☐ Legal investigation
- ☐ Application for insurance
- ☐ Disability determination
- ☐ Personal
- ☐ Other

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: ____________________________________