Lake Travis Eye
& LASER CENTER

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Full Name: _____ DOB: _____

Previous/Other Name: _____ (If different than patient listed above)

This will authorize:	**To release to:**
Name: _____	**Name: _____**
Address: _____	**Address: _____**
City, State, Zip: _____	**City, State, Zip: _____**
Phone, Fax: _____	**Phone, Fax: _____**

GENERAL INFORMATION REQUESTED

Medical Information Requested:
___ Complete Medical Records
___ Lab Reports
___ Progress notes, including medication list
___ Immunization
___ Other: _____

Reason for Release:
___ To update my regular doctor (provider)
___ I have been referred to another doctor
___ I want/need a second opinion
___ I am changing doctor (provider)
___ Dissatisfaction with care
___ My insurance changed
___ I am moving (new address)
___ Other: _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information relating to (note, you must circle yes or no):

Yes/No Substance Abuse (alcohol/drug abuse)

Yes/No Mental Health/Depression (includes psychological testing)

Yes/No HIV-Related Information (AIDS related testing)

This consent may be revoked at any time by notifying the above-named provider of information.
Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosed information may be reviewed by contacting the provider of information.
RESTRICTIONS: The authorization is being given with the understanding that the receiver may not further use of disclose the medical information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.

_____	_____
Signature of patient or authorized representative	**Witness**
_____	_____
Date	**Date**