GLAUCOMA ASSOCIATES OF TEXAS

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Patient Authorization To Release Protected Health Information

I authorize Glaucoma Associates of Texas to release protected health information to the individual (s) listed below for the purpose of assisting with my care and/or payment.

Name	Relation	Phone Number
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Description of the information to be used or disclosed (*check all that apply):*

- ☐ Patient's demographic information
- ☐ Patient's medical information
- ☐ Patient's billing information
- ☐ Appointment Status

I understand that this authorization will be in effect during the time period I am a patient at Glaucoma Associates of Texas.

I further understand that this authorization is voluntary and that my health care and the payment of my health care will not be affected if I do not sign this form.

I further understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

I further understand that I may revoke this authorization at any time by notifying Glaucoma Associates of Texas in writing at 10740 N. Central Expressway, Suite 300, Dallas, TX 75231. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Signature of Patient or Patient's Representative _____ Date _____

Printed name of Patient's or Patient's Representative _____

Relationship to Patient or Legal Authority _____