Austin Pediatric Ophthalmology & Strabismus, P.A. Megyn L. Busse M.D.

Authorization for Release of Medical Information

I hereby authorize the following information to be released from the medical record of:

Patient Name: _____

Date of birth: _____ Social Security # _____

Address: _____ City: _____ State: ____ Zip: _____

Telephone Number: (_____) _____ Treatment Date: _____

This information is to be released:

To: _____

_____

_____

_____

City State Zip

From: Megyn L. Busse
Austin Pediatric Ophthalmology & Strabismus
4700 Seton Center Parkway, Suite 150
Austin, TX 78759

PLEASE CHECK INFORMATION REQUIRED TO BE RELEASED:

_____ Clinic Notes
_____ Progress Notes
_____ Operative Report
_____ History & Physical
_____ Physician Orders
_____ Discharge Summary
_____ Lab Reports
_____ EKG, EEG, EMG
_____ Pathology Report
_____ X-Ray Reports
_____ X-Ray Film
_____ Other (Specify)
_____

Purpose of Disclosure:

_____ Continued Patient Care
_____ Personal Use
_____ Commercial Insurance
_____ Attorney/Legal
_____ Worker's Compensation
_____ Other (Specify) _____
_____

It is further understood that the information released is for the specific purpose stated above and may not be provided in whole or part to any other agency, organization or person. This consent will expire 180 days after date of signature.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient Witness

Complete only if information is to be released directly to the patient:

I understand that my medical record may contain reports, tests 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 any misunderstanding of the information that has been written in the record. I will not hold the party releasing the information liable for any misinterpretation of the information in my medical record, as a result of not consulting my physician for the correct interpretation.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient Witness