South Texas Eye Consultants, PLLC

5402 S. Staples Ste.100
Corpus Christi, Texas 78411
Phone 361-992-9400 Fax 361-992-3907

Authorization for Release of Patient Health Care Information

Patient Name: _____ Date of Birth: _____

Contact Phone: _____ SSN: _____

I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and then would no longer be protected by federal privacy regulations.

I may revoke this authorization by notifying South Texas Eye Consultants in writing. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment on whether or not I sign the authorization.

HIV / AIDS: I DO _____ DO NOT _____ consent to the release of any positive or negative test results for AIDS or HIV infection. Antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. **Initial: _____ Date: _____**

The following person, physician, group or entity may release protected health information for the above named patient.
Name and **COMPLETE** address: _____
_____
_____

Dates of Service _____Most recent two (2) years
_____ Specific dates of service _____

My purpose for / intended use of this information is _____

TO: □ **John B. Sohocki II, M.D.** □ **Thomas R. Dietze, M.D.**
□ **Shahed Y. Ghoghawala, M.D.** □ **Lawrence C.R. Tafoya, M.D., Ph.D.**
□ **Richard Avila Jr., O.D.**

This authorization will expire in one (1) year after the date on this request.

By signing this form, I authorize South Texas Eye Consultants to release my confidential health information, by releasing a copy of my medical records, summary or narrative of my protected health information, to the person (s) or entity listed above.

_____ _____
Signature of Patient or Representative **Date**

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.