



GLAUCOMA INSTITUTE OF AUSTIN

Authorization for Medical Records Release

I hereby authorize: _____

ph: _____

fax: _____

to release information from the medical records of _____
Patient's Name

SS#

DOB

Specific request of:

- Entire Medical Records** Surgical History Visual Fields
 Fundus Photos / OCT's Other _____ Correspondence Letters
 Insurance Information

to be released to: **GLAUCOMA INSTITUTE OF AUSTIN**
901 W. 38th St., Ste. 303
Austin, TX 78705
ph: 512.452.8467
fax: 512.452.8440

Please release information via: fax mail

Patient's Signature

Date