GLAUCOMA INSTITUTE OF AUSTIN

Authorization for Medical Records Release

I hereby authorize: GLAUCOMA INSTITUTE OF AUSTIN
901 W. 38th St., Ste. 303
Austin, TX 78705
ph: 512. 452. 8467
fax: 512. 452. 8440

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: _____
_____
_____
ph:_____
fax:_____

Please release information via: ◯ fax ◯ mail

_____ _____
Patient's Signature **Date**