AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Little Elm Eye Care, P.A.
1200 E. Eldorado Pkwy, Ste. 100
Little Elm, TX 75068
972-292-0900
Bert Bubela, Privacy Official

Patient Name _____

Patient Address _____

Patient Phone Number _____

I authorize Little Elm Eye Care, P.A. to release health information identifying me to the following individuals:

_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient

It is completely your decision whether or not to sign this authorization form. We will not refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you may revoke it at any time by contacting in writing, FAX or email the Privacy Official noted in the *Notice of Privacy Practices*.

When your health information is disclosed under this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____	_____
Patient	Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____	_____
Representative	Relationship to Patient