OAK HILL EYE CARE

6000 W. William Cannon Drive, A-100
Austin, TX 78749
Ph: 512-288-0444
Fax: 512-288-1009

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____

DOB: _____

This is my full and sufficient authorization to release my medical records ***from / to:***

Oak Hill Eye Care

And their representatives/employees, all treatment and medical information obtained at any time while I was a patient at their facility.

Please release my records **to / from**:

Name: _____

Address: _____

Phone: _____ **Fax**: _____

Patient/Guardian Signature: _____ **Date**: _____