AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Texas State Optical (TSO) Woodlands
1570 Lake Woodlands Drive
The Woodlands, TX 77380
(281) 681-3937

Patient Name _____

Patient Date of Birth _____

Patient Phone Number _____

I authorize Texas State Optical (TSO) Woodlands to release health information identifying me (including, if applicable, information about substance abuse, mental health conditions, and HIV infection or AIDS) under the following conditions:

I. Information to be released (check one):

- ☐ All records (including medical records & prescriptions)
- ☐ Limited records (prescriptions only)
- ☐ Limited records (medical records only)
- ☐ Limited records. Please specify:_____

II. Person(s) to whom it will be released: _____

III. Relationship (please circle): Spouse / Parent / Guardian / Sibling / Caregiver / Friend / Other

IV. Purpose of the release:

- ☐ New Authorization Form
- ☐ Updated Authorization Form

V. Expiration date for the purpose or event:

- ☐ No expiration date
- ☐ Specific date: _____

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 Signature Date

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

_____ _____

Representative Signature Relationship to Patient