Park Cities
EYE ASSOCIATES

Cathy Ann Norton, O.D.
www.parkcitieseye.com

8115 Preston Rd., Suite 630
Dallas, Texas 75225
Office (214) 360-9951
Fax (214) 360-9819

PHI WAIVER - AUTHORIZATION FORM
FOR RELEASE OF PERSONAL INFORMATION

Patient Name: _____

Patient DOB: _____

I authorize Dr. Norton and the staff of Park Cities Eye Associates to disclose confidential protected health information (including but not limited to: spectacle and contact prescriptions, medical history and eye examination findings and records, billing and fees information, and insurance and claims information) to the person listed below.

Name: _____

Relationship : _____

This authorization is indefinite (does not expire) unless revoked in writing. I understand that I may revoke this authorization. To revoke authorization to the personal listed above, I understand that I must contact Park Cities Eye Associates in writing.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

_____
Witness Printed Name