AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION
TO RESOLUTION EYECARE

Patient Name _____

Date of Birth _____

Address _____

I hereby authorize:

Name _____

Address _____

Phone _____

Fax _____

To **RELEASE** confidential information from my/my minor child's medical record(s) **TO**:

RESOLUTION EYECARE
6929 Airport Blvd Ste 165
Austin, TX 78752
Ph: 512-580-9035
Fax: 512-201-4801

I understand that I may revoke this consent at any time, except where information has already been released.

Date: _____

_____

Name: (Print - Parent or Legal Guardian if Minor Child)

_____

Signature

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