RELEASE OF INFORMATION

Patient Name (Print)	Date of Birth	Social Security Number

Maiden Name or Previous Name	Parent(s) Name if Minor

I HEREBY AUTHORIZE INFORMATION TO BE RELEASED FROM:

PLEASE GIVE/SEND THIS INFORMATION TO:

Dr. Nathan Berry Dr. Adam Stewart Dr. Matthew Nickell Dr. Jessica Hall
Berry Stewart Eye Center
2790 SW Wilshire Blvd.
Burleson, TX 76028
817-484-2020
817-484-2015 Fax

This information can be released as instructed, including medical documentation, opinion, or assistance about reports, records, or x-rays, or any other information or documents that you may have in your custody or in your control, with reference to me.

I specifically authorize the following to be released. This confidential information is protected by Federal and/or State Law*.
Please indicate YES or NO and please initial for your authorization.

YES_____NO_____ Mental Illness information
YES_____NO_____ Aids or HIV-related information
YES_____NO_____ Drug or Alcohol abuse information

Special instructions (if limiting to specific dates or information, etc.)

- ☐ Entire Medical Record
- ☐ Medical Record from _____(date) to _____(date)
- ☐ Last 2 Visual fields

The purpose of this disclosure is:

1. __x___ Medical Care
2. _____Insurance Purposes
3. _____Other_____

_____ _____
PATIENT SIGNATURE DATE

PARENT/LEGAL REPRESENTATIVE SIGNATURE (IF APPROPRIATE)

This waiver expires one year after the date hereof. I understand that I may revoke this authorization at any time by giving written notice.
***Note:** Re-disclosure of this information without further written consent is prohibited. The receiver may NOT further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.
A photocopy or facsimile of this authorization, as duly executed, shall have the same force and effect as this original.