Garland Eye Associates, P.A.
1626 Forest Lane Suite B
Garland, TX 75042
Office 972-272-5591 Fax 972-276-5413

Records Release Authorization

Please complete the following information:

Patient name_____ DOB _____

Address _____

City/State/Zip _____

Phone number_____

I hereby authorize and request _____ to release my records concerning my illness and/or treatment to:

Provider/Entity _____

Address_____

Phone number _____ Fax number_____

Patient signature _____ Date _____

Office representative's signature _____

Please tell us why you are requesting you health information by checking one of the following:

___ I am remaining a GEA patient, but also seeking care from an outside physician

___ I am leaving GEA because:

- ___ I am moving out of the GEA service area
- ___ I have a new insurance plan (please supply insurance name _____)
- ___ I was dissatisfied with some aspect of GEA

FOR OFFICE USE ONLY :	ACCT NO:	DATE SENT:	INITIALS: