



Ophthalmology  
Consultants, P.A.

Eye Muscle Specialist  
Pediatric Ophthalmologist  
Optometrist

3200 N. MacArthur Blvd  
Suite 200  
Irving, TX 75062

3050 S. Center St, Suite 110  
Arlington, TX 76014

**Everett A. Moody, MD**  
**Kartik Kumar, MD**  
**colleen Walters, MD**

4112 W. 15<sup>th</sup> St  
Suite 201  
Plano, TX 75093

526 N Locust St  
Denton, TX 76201

**Phone:972.258.7979 Fax: 972.570.5502**

### Authorization to Release Protected Health Information

Patient Name: _____	DOB: _____
Parent/ Legal Guardian: _____	Phone: _____
Address: _____	
_____	

I hereby authorize Ophthalmology Consultants, PA to release my health information to the following designee:

Recipient Name: _____	
Phone: _____	Fax: _____
Address: _____	
_____	

For the purpose of : (circle one):

Treatment    Payment    Healthcare Operations    Other: \_\_\_\_\_

Type of information to be released is as follows:
<input type="checkbox"/> Entire Record
<input type="checkbox"/> Operative Reports
<input type="checkbox"/> Consultation Reports
<input type="checkbox"/> Billing Records
<input type="checkbox"/> Other: _____

Date(s) of service from \_\_\_\_\_ to \_\_\_\_\_

- This authorization shall be in effect until revoked by me in writing.
- I understand that I may revoke this authorization at any time by notifying Ophthalmology Consultants, PA in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my health information has acted in reliance upon this authorization.
- I understand if the recipient authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal and state privacy regulations.
- I understand authorization for the use or disclosure of the information identified is voluntary. I need not sign this form to ensure health care treatment. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

\*There is a \$25 fee when applicable  
Please allow 15 days notice for releases.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date



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### **Authorization to Release Protected Health Information**

Self Parent/Guardian Power of Attorney Other

Identification verified by  Drivers License  Other picture ID (Name): \_\_\_\_\_ OCPA staff initials \_\_\_\_\_