OUSLEY VISION CENTER

Consent for Medical Records/Information

I,_____ [patient name] _____ [date of birth]

_____ [address] _____ [phone number]

_____ [city, state, zip]

Do hereby authorize: OUSLEY VISION CENTER
2430 FM 407 Suite A
Highland Village, Texas 75077
Fax: 972-317-2320
Phone number: 972-317-3937

To: release / obtain Medical Records to / from

_____ Name

_____ Address

_____ Phone Number

_____ Fax Number

_____ Patient will pick up

For the purpose of: [please circle]

Medical care Insurance other_____

I am requesting access to my health information through:

Copies of my last exam other_____

I understand that Ousley Vision Center may charge a fee for the costs of sending any information associated with my request.

_____ _____

Patient signature Date