Rudolf Churner M.D.
Sanjay K. Patel, M.D.
James Norbury, Jr., M.D.
Joseph Constable, O.D.

Heritage Eye Center
1501 Redbud Blvd.
McKinney, TX 75069
972-548-0771 FAX 972-562-2300

Dear Dr. _____:

This letter will authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the X mark below) to the party of institution listed below.

_____ Complete Medical Records
_____ Records of care from _____ to _____ only
_____ Records of care concerning the following conditions

The reason or purpose of information is as follows:

Mail to: _____, M.D.
1501 Redbud Blvd.
McKinney, TX 75069

REQUEST OF RELEASE OF INFORMATON

Date: _____
To: _____
_____
_____

I understand that I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to the Physician/Heritage Eye Center receiving the revocation.

We are happy to provide one copy of your records at no cost. A $35.00 medical record fee is required for any additional records requested to send to you or to be sent to another physician.

_____ _____
Signature of Patient/Patient Representative Relationship to Patient

_____ _____ _____
Printed Name of Patient Date of Birth Date