AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name_____Date:_____

Patient address _____

Patient phone number _____

I authorize _____ to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released:_____

2. To whom may the information to be released: Westheimer Vision Associates

   10260 Westheimer, Suite 580; Houston, Texas 77042

   713-781-3517; Fax: 713-783-9025

We cannot refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you can revoke it later.

I have read and understand this form. I am signing it voluntarily. I authorize the disclosure of my health information as described in this form.

_____ _____

Dated Patient's Signature

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

_____ _____

Relationship to Patient Print Name

_____

Source of Authority