



# Family Vision Center of Crosby

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## CONSENT FOR RELEASE OF MEDICAL RECORDS AND USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO A THIRD PARTY

I, \_\_\_\_\_ (Name of Patient making Request) with a date of birth, \_\_\_\_\_, give my permission for \_\_\_\_\_ (Name of Doctor or Hospital) to give my medical records to **Family Vision Center of Crosby** so that they can better understand my condition.

### Requesting records from:

Name of Practice: \_\_\_\_\_  
Name of Physician: \_\_\_\_\_  
Phone/Fax number: \_\_\_\_\_  
Address: \_\_\_\_\_

### Types of records we are requesting:

- My entire medical record
- Test Results only
- Date specific Portions of my Medical Record, From Date: \_\_\_\_\_ To Date: \_\_\_\_\_

**Send a copy of my records to this address/fax:** Family Vision Center of Crosby  
14700 FM 2100 Ste.3, Crosby ,TX.77532  
P: (281) 328-2020/F: (281) 328-8394

I acknowledge that this Healthcare Facility, in accordance with their Notice of Privacy Practices (NOPP) and Omnibus HIPAA Law will release my specified medical records to the party listed above. I have reviewed this Practices Notice of Privacy Practices (NOPP) and have been given an opportunity to ask questions about it, understand it, and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. This form is only good for 90 days from date I sign it. I release, hold harmless and agree to indemnify this Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent. I specifically authorize this Practice to use and disclose verbally, by mail, fax or unencrypted email, the following types of super-confidential information as stated in the NOPP (initial where appropriate):

**By Patient:** \_\_\_\_\_ Date: \_\_\_\_\_  
(Print name and sign)  
or  
By Patient's Representative \_\_\_\_\_ Date: \_\_\_\_\_  
(Print name, sign, and describe authority)

### OFFICE USE ONLY

Describe what alternative communications were denied this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_  
\_\_\_\_\_

Describe what alternative communications were accepted this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_  
\_\_\_\_\_