

Sanjay K. Patel, M.D.
James Norbury, Jr., M.D.
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Heritage Eye Center
1501 Redbud Blvd.
McKinney, TX 75069
972-548-0771 972-562-2300 (fax)

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 INFORMATION

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. *This release will be effective for one year from date of signature.

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