



DIETLEIN & LABBE EYE ASSOCIATES

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Authorization of Release of Information

Name of Provider:

- Jon F. Dietlein, M.D.
- Thad A. Labbe, M.D.
- Cynthia Wasser, O.D.

I hereby request and authorize the release of information from the health record(s) of:

Patient _____ Date of Birth _____

Address _____ Phone# _____

This instrument is to request and authorize you to release and send all the information in my medical records to:

Physician / Clinic / Myself: _____

Address: _____

Phone#: _____ Fax#: _____

Purpose/ Reason for release of records:

- Continuous Medical Care
 Insurance
 Legal Matter
 Research
 Other (explain) _____

I understand that there is a \$25 charge for obtaining copies of my records. This fee is based off the fee schedule established in the Texas Administrative Code. Payment for my records is required before the release of my records to either myself, a clinic, or physician.

Patient Signature: _____

Witnessed by: _____