DIETLEIN EYE & LASER CENTER

JON F. DIETLEIN, M.D., P.A.
THAD A. LABBE, M.D.
PAMELA EVANS, O.D.

311 River Bend Dr.
Georgetown, Texas 78628
Phone: (512) 930-EYES (3937)
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Authorization of Release of Information

Name of Provider:

- Jon F. Dietlein, M.D.
- Thad A. Labbe, M.D.
- Pamela Evans, 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: _____