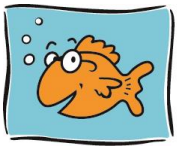

CHILDREN'S EYE CENTER
of South Texas, P.A.

Charles S. McCash, M.D. and Rachel Cooley, M.D.
Pediatric Ophthalmology & Eye Alignment Disorders

Keith Williams, O.D.
Therapeutic Optometrist

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name:_____ Date of Birth:_____

Address:_____ City/State/Zip:_____

I consent and authorize you to release the following information to:

Children's Eye Center of South Texas, PA
1314 E. Sonterra, Suite 5201
San Antonio, TX 78258
Phone: 210-340-6633 Fax: 210-340-6390

or

To:_____ _____ _____
Name of Physician/Facility Phone Fax

INFORMATION TO BE RELEASED:

□ All Clinic Records □ Visual Fields □ Lab Reports □ Eye Records □ Office Notes

□ Operative Report □ X-Ray, CT, MRI Reports, Films □ Other:_____

For the following dates:_____

I understand that if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information may be redisclosed and no longer protected by these regulations. I understand that I may revoke this authorization at any time by a written notice to the releasing entity. I further understand that any action taken on this authorization prior to the rescinded date may not be revoked. I understand that this authorization shall be valid for one (1) year unless otherwise stated or revoked through written notice to Children's Eye Center of South Texas, P.A.

Patient/Guardian Signature:_____ Relationship:_____ Date:_____