



**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**  
**1439 E. Sonterra Blvd.**  
**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 I further understand that any action taken on this authorization prior to the rescinded date may not be revoked.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: \_\_\_\_\_