

**Plano Office**  
4100 W. 15<sup>th</sup> Street #210  
Plano, Texas 75093



**Lewis J. Frazee, M.D.**  
**James A. Passmore, M.D.**  
**Ellen Ngo, M.D.**

**Lewisville Office**  
751 Hebron Pkwy #230  
Lewisville, Texas 75057

**Phone: 972-867-7777**  
**Fax: 972-519-1679**

**Medical Records Authorization Form**

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**To Whom the records are to be released:**

Doctors Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

- Medical Records**
- Include testing images**
- Include HIV information (if this applies)**
- Do not include HIV information (if this applies)**
- Contact lens records**
- Summarizations of medical history**

**Reason (s) for this records release request:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of patient or responsible party

\_\_\_\_\_  
Date



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### **Medical Records Authorization Fee Form**

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

North Texas Eye Center will provide your records to you once you have completed and signed the medical records release authorization form. You can find this form on our website at [www.northtexaseyecenter.com](http://www.northtexaseyecenter.com), or you may come to one of our office locations to complete this form. After completing the authorization form, you may either fax or mail the form to our Lewisville office.

Your request will be processed and fulfilled within 14 business days. We will mail or fax the records to the doctor on the authorization form.

Listed below are charges for copying medical records:

Pages 1-20	\$25.00
Pages +21	\$0.50 per page
Testing Images	\$8.00 per page
Mailing Fee	\$3.00

All fees allowed by the Texas Medical Practice Act.

**This form is to notify you that the office of North Texas Eye Center will apply the appropriate fee to your account for the request of medical records. Medical records will not be processed until payment is made in full.**

**In order to comply with federal laws including HIPPA, as well as Texas State and Federal Statues, this office must have a signed authorization form from the patient or responsible party stating who we are authorized to release information to.**

\_\_\_\_\_  
Signature of patient or responsible party

\_\_\_\_\_  
Date