Plano Office
4100 W. 15th Street #210
Plano, Texas 75093

Lewisville Office
751 Hebron Pkwy #230
Lewisville, Texas 75057

NTEC
North Texas Eye Center

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

Phone: 972-867-7777
Fax: 972-315-1394

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

Lewis J. Frazee, M.D.
James A. Passmore, M.D.

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, 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