February 3, 2021

Dear Patient:

We hope that you are doing well amidst this challenging and unpredictable year. Like many practices we have undergone changes. KE Eye Centers of Texas/EVP has decided to permanently and completely discontinue offering oculoplastic services to focus on their core ocular services of general ophthalmology. I, Carrie L. Morris, MD, FACS will be continuing my practice in Southlake and Granbury, Texas, still serving all of the Dallas – Fort Worth area and surrounding communities. We are working to make the transition as easy and seamless as possible for our patients. My phone and fax numbers will remain the same as well my website address. My Granbury office address will also remain the same. Please feel free to reach out to our staff in the coming weeks if you need anything during this time of transition. At this time we have not been able to obtain patient records from KE Eye Centers of Texas directly, if you would like your records transferred so that you can continue your care, we have attached a medical records release form. You will also be receiving one via docusign, if you choose to complete the form electronically. Otherwise please print, sign, and scan. You should email it to refreshedface@carriemorrismd.com so we can follow up on all record requests upon your behalf.

Thank you for your support in advance.

May the New Year bring blessings and health to all,

Carrie L. Morris, MD, FACS

Updated Contact Information:

Carrie Lynn Morris, MD, PLLC

620 N Kimball Ave Ste 110

Southlake, TX 76092

Ph: 972-922-3016

Fax:817-796-1325

refreshedface@carriemorrismd.com

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name:_____DOB _____

Phone: H) _____ **Phone: W) _____**

Address:_____ **City/State/Zip: _____**

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: __KE EYE CENTERS OF TEXAS/KLEIMAN EVANGELISTA **Facility Phone: 817-717-6364**

Facility Address:1825 E SOUTHLAKE BLVD
_____

City, ST, Zip: SOUTHLAKE TX 76092

_____

Dates and Type of information to disclose:

ALL INFORMATION OF RECORD

2 years prior from last date seen

Dates Other: _____
Specific Information Requested:

PLEASE EMAIL RECORDS IN PDF FORMAT EXCEPT PHOTOS IN JPEG

RESTRICTIONS: This authorization is valid only for the release of medical information dated prior to and including the date on this a uthorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease,

information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: CARRIE LYNN MORRIS, MD PLLC

_____

Address: 620 N KIMBALL AVE STE 110

_____

City, State, Zip: SOUTHLAKE, TX 76092

_____

PLEASE EMAIL RECORDS IN PDF FORMAT EXCEPT PHOTOS IN JPEG

Email:
REFRESHEDFACE@CARRIEMORRISMD.COM _____

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

Date

_____ _____

Printed name of Authorized Representative

Relationship / Capacity to patient