Patient Name: _____

ARKANSAS EYE SITE

Authorization to Release Patient Information:

I, _____, hereby authorize Arkansas Eye Site to discuss and release any medical information to the persons named below. This includes glasses/contact lens pick-ups, appointment information, and permission to contact them if unable to reach me when necessary.

Name: _____
Relationship: _____
Phone Number: _____

Name: _____
Relationship: _____
Phone Number: _____

Name: _____
Relationship: _____
Phone Number: _____

Name: _____
Relationship: _____
Phone Number: _____

I acknowledge that I have been given the opportunity to receive a copy of Arkansas Eye Site's Notice of Privacy Policy.

Patient Name: _____ DOB: _____
Patient Signature/Representative: _____
Representative's Relationship: _____ Date: _____