ARKANSAS EYE SITE

800 Professional Acres Drive
Jonesboro, AR 72401
870-333-1087
Fax: 870-333-1088
www.arkansaseyesite.com

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name_____ DOB: _____

Patient address _____

Patient phone number _____

I authorize, _____, to release health information identifying me (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

1. Information to be released: _____
2. To whom may the information to be released: **Arkansas Eye Site, fax 870-333-1088**
3. Expiration date: _____

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note stating that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated _____ Patient Signature _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____ Print Name _____

Source of Authority _____