EYE PHYSICIANS AND SURGEONS

521 Marshall Road
Jacksonville, AR 72076
(501) 985-0616 PHONE
(501) 985-0715 FAX

Please send a copy of this release with the requested records.

PATIENT INFORMATION (Please print)		
Patient Name	Date of Birth	Social Security Number
Address, City, Zip		Phone

INDICATE PHYSICIAN RELEASE INFORMATION	
I authorize release of my medical record **FROM**:	
Physician/Facility	
Address, City, Zip	Phone

Please send my medical record **TO**:	
Physician/Facility	
Address, City, Zip	Phone

RELEASE THE FOLLOWING INFORMATION		
Complete Record		Date Range:
Exams Only		Other:
>Please allow 15 days for processing. >Incomplete information will delay processing. >This information is for the use of the designated recipient only and cannot be provided to any other agency.		

CONSENT

I authorize the release of all information indicated, and I am aware that the records released may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol abuse.

	YES	NO
I authorize the release of HIV/HTLV/AIDS test results.		
I understand there may be a charge for copies provided.		

If you are not the patient, please indicate your relationship to the patient.	
Signature	Date

THIS CONSENT IS VALID FOR 90 DAYS. IT MAY BE REVOKED BY THE SIGNER AT ANY TIME.