

Authorization for Release of Records

\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

*I authorize the following protected health information to be released from the record of:*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LAST NAME (PLEASE PRINT) FIRST NAME (PLEASE PRINT) DATE OF BIRTH

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE NUMBER

Requested Date(s)/Years of record profile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 All Records

 Spectacle and/or Contact Lens Prescription

 NOTE: ***If specific dates to be released are not indicated, all records will be released.***

*Release Records From*: *Release Records TO:*

Vance Vision Clinic If same as above

7345 Hwy 62 West OR:

Gassville, AR 72635 NAME/ORGANIZATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_\_\_\_\_\_\_

 PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Please call when my records are ready for pick-up (Must show valid photo ID at pick-up)

OR

 Please fax my records to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE OF PATIENT (OR LEGAL REPRESENTATIVE-POA) DATE

 \*\*\* Please fax completed form along with a copy of your photo ID to 870-471-9029\*\*\*