Medical Records Release Form

Patient: _____ **DOB:** _____ **Date:** _____

Please Sign At Bottom -

I Hereby Authorize: ***Leave blank - to be completed at office***
(Name & Address of releasing facility)

_____

_____

_____

To Release Information to:

Jeffries Eye Associates

3602 Southern Hills Blvd

Rogers, AR 72758

PURPOSE OF DISCLOSURE:

( )	Continuing Care	( )	Legal	( )	For Personal Use
( )	School	( )	Worker's Compensation		
( )	Other (Specify):_____				

INFORMATION TO BE RELEASED: (Please check all that apply)

( )	Complete Medical Record	( )	Diagnostic test reports	( )	Exams
( )	Procedure Reports	( )	Other: _____		

ACKNOWLEDGEMENT OF UNDERSTANDING:

- **I understand that the information in my medical records may include information relating to communicable disease(s), Acquired Immunodeficiency Syndrome ("AIDS"), or Human Immunodeficiency Virus ("HIV"), behavioral or mental health, alcohol/drug abuse or any such related information.**
- **I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it well be effective on the date notified except to the extent action had already been taken.**
- **I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.**
- **I understand by authorizing this use disclosure of information, there will be no conditions placed on my health care or payment for my health care.**

X _____
SIGNATURE OF PATIENT (Guardian or Parent Signature, if minor)

Jeffries Eye Associates
3602 Southern Hills Blvd
Rogers, AR 72758
479-756-5500 / 479-631-8900
479-756-2000 Fax