Eyes on the Square

107 S Main St
Bentonville, AR 72712
Phone: (479) 339-9010 Fax: (479) 339-9011
Email Records to info@eyesonthesquare.com

Authorization for Release of Medical Information

Patient's Name:	Date of Birth:
Date of Request:	Date Needed:

OR

☐ I authorize Eyes on the Square **to release information to**:	☐ I authorize Eyes on the Square to **obtain information from:**
Name of Provider or Facility	Name of Provider or Facility
Address	Address
Phone # / Fax #	Phone # / Fax #

PURPOSE FOR THIS REQUEST: (Check one)
☐ Transfer of Care ☐ Insurance Coverage

TYPE OF RECORDS REQUESTED: (Check one)
☐ Entire copy of medical record including last medical and vision insurance information on file.
☐ Specific Information: (Select one or more, as applicable)
☐ Last Examination ☐ Photos ☐ Lab Results ☐ Other
☐ Last examination including last medical and vision insurance information on file.

AUTHORIZATION VALID FOR: (Check one)
☐ One year from the date of this authorization OR ________________ (insert date). This authorization applies to the records of treatment received on or prior to the date of this authorization.

***I understand that*:**

- My right to healthcare treatment is not conditioned under this authorization.
- I may cancel this authorization at any time by submitting a ***written*** request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.

NOTE: Medical records are faxed to (479) 339-9011 or emailed to info@eyesonthesquare.com

Signature of Patient or Representative: Date:
Relationship to Patient: (*if requester is not the patient*)

Office use only:
MR#: Date: Staff Member Sending: