

**Release of Patient Medical Information**

Clinic Patients

In order to protect your medical information, please list individuals with whom *Ozark Eye Center* may discuss your health care needs.

I \_\_\_\_\_ give *Ozark Eye Center* permission to share  
(Your name)

information about my health care needs with: *(please list below the names of the individuals)*

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

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Please notify *Ozark Eye Center* of any change of contact person(s) or revocation of authorization concerning your Patient Medical Information (valid for six (6) years).

Thank you,  
Ozark Eye Center

*Below this line to be completed by Ozark Eye Center staff*

-----  
**reviewed by staff:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*reviewed & updated* \_\_\_\_\_ *reviewed & updated* \_\_\_\_\_ *reviewed & updated* \_\_\_\_\_

*reviewed & updated* \_\_\_\_\_ *reviewed & updated* \_\_\_\_\_ *reviewed & updated* \_\_\_\_\_

*reviewed & updated* \_\_\_\_\_ *reviewed & updated* \_\_\_\_\_ *reviewed & updated* \_\_\_\_\_