Ozark Eye Center

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870-425-2277
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Release Form

- **Permission to Speak to Individuals Involved in Patient's Care**
- **Including Financial Responsibility**

I, _____, give **Ozark Eye Center** permission to speak with the following people regarding my health status for health services I receive from **Ozark Eye Center**, to include, but limited to: Diagnosis, Treatment Options, Financial Plans, Payments and Account Balances.

This consent is valid beginning today, until such time as I provide **Ozark Eye Center** a written Revocation of Consent.

Ozark Eye Center and their employees may speak with the following:

Name: _____

Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Name: _____

Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Name: _____

Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

_____ _____

Signature of Patient Date