Ozark Eye Center

360 Highway 5 North
Mountain Home, AR 72653

William D. Hill, M.D.
Allison S. Booth, M.D.
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Records Release Authorization

Date _____ Patient Name _____

Address _____

City _____

Date of Birth _____

Name of Previous **Eye Doctor** or **Eye Clinic:**

_____

(Name of Eye Doctor or Eye Clinic who you are authorizing to release information.)

_____

Street Address City State Zip Code

Release information to: Ozark Eye Center

Check Records to be Released:

- ☐ Last 4 Eye Exams
- ☐ Injection History 1 Year
- ☐ Lab
- ☐ Operative Reports
- ☐ Other _____

_____ _____

(Signature of Patient) (Signature of Witness)