

**LITTLE ROCK EYE CLINIC**

9800 Lile Drive  
Suite 400  
Little Rock, AR 72205  
Phone: (501) 224-5658  
800-537-8054  
www.littlerockeye.com

**LITTLE ROCK EYE CLINIC - WEST**

4200 N. Rodney Parham Road  
Suite 101  
Little Rock, AR 72212  
Phone: (501) 687-0800

Cliff Clifton, M.D., P.A.  
J. Charles Henry, M.D., P.A.  
Michael Roberson, M.D., P.A.  
Tracy Baltz, M.D., P.A.  
Dan Hennessey, O.D.  
Andrew W. Lawton, M.D.  
Edwin Hankins, III, M.D.  
Monica Dellimore, M.D.  
Lydia L. Dworkin, M.D. .

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**RECORDS RELEASE AUTHORIZATION**

\_\_\_\_\_ I authorize and request that **Little Rock Eye Clinic release** any information regarding my diagnosis and treatment.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Request

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient or Legal Representative Signature

\_\_\_\_\_  
Relationship to Patient

**Information to be Released:**

Billing Information (Insurance, Account Ledger)

**Dates of Service:** \_\_\_\_\_

Demographics (Personal Information)

Clinical Records

(Patient Notes, Tests, Op Reports, Labwork, H&P, D/C Summary, Medical History Summary)

**Dates of Treatment:** \_\_\_\_\_

Records or Correspondence from Other Physicians

Entire Record

Other: \_\_\_\_\_

**Purpose of Disclosure:**

Medical Care

Personal Information

Insurance

Other: \_\_\_\_\_

**To:** \_\_\_\_\_  
Doctor Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

**DISCLOSURE AUTHORIZATION ON REVERSE SIDE**

## AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I understand that authorizing the disclosure of this health information is voluntary. I understand that I may inspect or choose information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Officer of this corporation.

I understand that I have a right to revoke this authorization at anytime. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Privacy Officer of this organization. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company as the law provides my insurer with the right to contest a claim under my policy. Unless otherwise specified, this authorization will **expire six months from the date of request** on the front of this form.

Expiration Date: \_\_\_\_\_

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

\_\_\_\_\_  
Signature of the patient or legal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to the patient if other than the patient

\_\_\_\_\_  
Signature of Witness