



## Jeffries Eye Clinic, P.A.

Due to confidentiality laws, it is necessary for us to have written authorization to share your personal information with friend or family member should you become incapacitated or unable to deal with your business affairs for any reason. Please list any individuals you would utilize in case of this event.

1. I authorize Jeffries Eye Clinic, P.A. to release necessary medical and /or financial information about myself, \_\_\_\_\_, \_\_\_\_\_ to  
( my name) (my date of birth)  
my \_\_\_\_\_  
(relationship) (name)
2. I authorize Jeffries Eye Clinic, P.A. to release necessary medical and /or financial information to my \_\_\_\_\_  
(relationship) (name)
3. I authorize Jeffries Eye Clinic, P.A. to release necessary medical and /or financial information to my \_\_\_\_\_  
(relationship) (name)
4. I authorize Jeffries Eye Clinic, P.A. to release necessary medical and /or financial information to my \_\_\_\_\_  
(relationship) (name)
5. I authorize Jeffries Eye Clinic, P.A. to release necessary medical and /or financial information to my \_\_\_\_\_  
(relationship) (name)
6. I authorize Jeffries Eye Clinic, P.A. to release necessary medical and /or financial information to my \_\_\_\_\_  
(relationship) (name)

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_



Jeffries Eye Clinic, P.A.

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**Jeffries Eye Clinic, P.A.**

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