PATIENT AUTHORIZATION FORM

I,_____, HEREBY AUTHORIZE WAL-MART VISION CENTER OPTICIANS ACCESS TO MY PATIENT FILES AS MAY BE DIRECTED BY STEVEN D. BRAVARD, O.D., AS NEEDED IN PROVIDING MY VISION TREATMENT. I UNDERSTAND THAT WAL-MART OPTICIANS ARE NOT EMPLOYEES OF DR. BRAVARD.

I AUTHORIZE DOCTORS DESIGNATED BY DR. BRAVARD TO ACCESS MY PATIENT FILES AS MAY BE NECESSARY TO PROVIDE MY VISION TREATMENT.

I AUTHORIZE ANY OTHER DOCTOR PROVIDING MY VISION TREATMENT IN DR. BRAVARD'S ABSENCE TO RELEASE THOSE MEDICAL RECORDS TO DR. BRAVARD. IT IS MY INTENT THAT MY PATIENT RECORDS BE RETAINED BY DR. BRAVARD AT HIS OFFICE LOCATED AT 700 S. BOWMAN RD, LITTLE ROCK, AR. I UNDERSTAND THAT THE OPTOMETRISTS SEEING PATIENTS AT THIS OFFICE IN DR. BRAVARD'S ABSENCE ARE NOT EMPLOYEES OF DR. BRAVARD.

I AUTHORIZE DR. BRAVARD TO RELEASE INFORMATION RELATED TO MY INSURANCE COVERAGE AND FEES FOR MY SERVICES TO MEDICAL BILLING AGENCIES, FOR THE LIMITED PURPOSE OF FILING CLAIMS WITH MY INSURANCE CARRIER.

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL I NOTIFY DR. BRAVARD IN WRITING AT 700 S. BOWMAN RD, LITTLE ROCK, AR.

_____ _____

(Print Name) (Date)