RECORDS RELEASE AUTHORITY

I, _____, hereby authorize
Print Patient Name

Eric A. Arp, DPM
801 S. College Street, Suite 1
Mountain Home, AR 72653

Telephone (870) 425-7363
Fax (870) 425-7387

to release a report of my treatment and/or x-rays, as well as other data pertinent to treatment of me from _____ to _____,
To: _____
_____

Reason for Records Request:

_____
_____
_____
_____

I understand that x-rays are property of this office and agree to return them within 60 days.

_____ _____
Date Signature of Patient, Parent, Guardian, Or Legal Representative

_____ _____
Patient's Date of Birth Street Address, City, State, and Zip Code

_____ _____
Witness Witness Name Printed