



Vision Therapy Center of Jonesboro, PLLC  
3705 E. Johnson Ave Suite B  
Jonesboro, AR 72401  
(870)336-2264  
vtjonesboro.com

I, \_\_\_\_\_ (Patient/Parent/Guardian) authorize \_\_\_\_\_  
(Physician/Clinic) to release my personal protected health records to **Vision Therapy Center of Jonesboro PLLC – Dr. Megan Moll OD.**

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

\_\_\_\_\_ I am requesting records for dates of service \_\_\_\_\_ to \_\_\_\_\_.

\_\_\_\_\_ I am requesting \_\_\_\_\_ (specific record).

Please release the records via facsimile to the attention of **Sarah at 870-336-2455 (fax #).**

Signature of Patient/ Parent/Guardian: \_\_\_\_\_

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

**Important Warning:**

This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message and information by error, please notify us immediately and destroy the related information