VISION THERAPY CENTER
OF JONESBORO PLLC

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: _____