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ACCESS TO PATIENT RECORDS CONSENT FORM

I hereby consent to Dr. Criger and Dr. Hefley allowing access to my patient file to Walmart Vision Center associates. I understand that Walmart Vision Center personnel are not employees of Dr. Criger, Dr. Hefley, or their practices.

I further consent to Dr. Criger and Dr. Hefley allowing access to other doctors and medical personnel who may require use of my patient file. I understand that the other doctors or medical personnel may not be employees of Dr. Criger, Dr. Hefley, or their practices.

Printed Name

Signature

Date

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received and reviewed a copy of Dr. Criger and Dr. Hefley's Notice of Privacy Practice.

Printed Name

Signature

Date

PATIENT REPRESENTATIVES

(People on this list will be able to access your Protected Health Information without special consent.)

	FIRST & LAST NAME	RELATIONSHIP
1.		
2.		
3.		
4.		
5.		