

MEDICAL RECORDS RELEASE AUTHORIZATION

I hereby authorize:

	Name of physic	cian or facility		
	Address			
	City	State	Zip	
Γo release the follow	ving records:	My entire medi	cal record	
	-	Labs/Pap		
	-	Other		
1. Any and all r	2300 Robinso Conway, AR PH. 501-548-6 given freely with ecords, whether v	72034 100 Fax 501-548-6105 In the understanding that written or oral or in elec-	: etronic form	at, are confidential and
		y prior authorization, ex horization is as valid as		
3. I may revoke released	this authorization	n at any time, except wl	hen informa	tion has already been
conditioned of	on whether I sign	t, payment, enrollment, this authorization in effect in until revoke		y of benefits will not be writing
Patient's Name		Social Security	#	Date of Birth
Patient's Signature		_		Date Signed