1ST CHOICE HEALTHCARE
Revolving around you

Medical Records Authorization/Test Results

Patient Name _____

SS# _____DOB _____

Address_____ City, ST, Zip_____

Please fax/mail to following location:

PROVIDER REQUESTING RECORDS:

____Tami Bell ____Michael Throesch

____**Ash Flat** 308 Hwy 62 W, Ash Flat 72513 — P: 870-994-2202 **F: 870-994-2328**

____Hutchison ____ Juan Cazano _____ Fletcher ____Danna Guntharp ____Jennifer Young ____Smith ____Murphy

____**Corning** 1300 Creason RD, Corning, AR 72422 — P:870-857-3399 **F:870-857-3301**

____Abbey Taber ____Patel

____**Paragould** #1 Medical DR, Paragould, AR 72450 — P:870-236-2000 **F:870-236-5861**

____George Guntharp ____Heather Hart ____Calixto Cazano ____Murphy ____Leah Privett ____Lunde ____ Reagan

____**Pocahontas** 141 Betty DR, Pocahontas, AR 72455 — P:870-892-9949 **F:870-892-0208**

____ Phillips ____Mike Bell _____Amy Hodges

____**Salem** PO Box 580, Salem, AR 72576 — P:870-895-2735 **F:870-895-2709**

_____Hunter ____ Edat ____Sandra Green ____Melissa Carter _____Reagan ____Alex Burns

____**Walnut Ridge** 201 Colonial DR, Walnut Ridge, AR 72476 — P:870-886-5507 **F:870-886-5632**

By signing this authorization, I authorize 1st Choice Healthcare, Inc. to obtain from OR release to the specified medical records to the indicated location.

From/To:

Point of contact name/ Doctor Name _____

Facility _____

Address _____

City, ST, ZIP_____

Phone # _____

Fax # _____

This authorization permits 1st Choice Healthcare, Inc. to obtain, use, or disclose the following individually identifiable health information about me:

Please send/fax the specified test result:

____PAP

____Mammogram

____Bone Density

____Colonoscopy

Reason for Request: X Treatment

This Authorization expires in:

____90 days ____120 days

____1 Year

_____Other date (not to exceed one year)

This practice ____will ____will not receive payment or other compensation from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from this practice. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer of this practice.

_____ _____

Signature of Patient/Legal Guardian & Relationship Date

_____

Print Name