



Medical Records Authorization/Mental Health Release

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 1<sup>st</sup> 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 1<sup>st</sup> Choice Healthcare, Inc. to obtain, use, or disclose the following individually identifiable health information about me:

<input type="checkbox"/> Office Notes dated _____ through _____ <input type="checkbox"/> Only items listed here: _____ <input type="checkbox"/> All Office notes in my chart, including test & consults as of the date of this authorization	<b>Reason for Request:</b> <input type="checkbox"/> Treatment <input type="checkbox"/> Insurance <input type="checkbox"/> Personal Use  <b>This Authorization expires in:</b> <input type="checkbox"/> 90 days <input type="checkbox"/> 120 days <input type="checkbox"/> 1 Year <input type="checkbox"/> Other date (not to exceed one year)
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THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE, OR RELATE TO MENTAL HEALTH, OR DRUG, SUBSTANCE OR ALCOHOL ABUSE.

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

\_\_\_\_\_  
Signature of Patient/Legal Guardian & Relationship

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name