1ST CHOICE HEALTHCARE
Revolving around you

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 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:

____Office Notes dated _____through _____

____Only items listed here:

_____

____All Office notes in my chart, including test & consults as of the date of this authorization

Reason for Request:

____Treatment ____Insurance ____Personal Use

This Authorization expires in:

____90 days ____120 days

____1 Year

_____Other date (not to exceed one year)

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