



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 ____ 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 ____ Murphy ____ Leah Privett ____ Jessica 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 ____ Jessica 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:

<p>Please send/fax the specified test result:</p> <p><input type="checkbox"/> PAP</p> <p><input type="checkbox"/> Mammogram</p> <p><input type="checkbox"/> Bone Density</p> <p><input type="checkbox"/> Colonoscopy</p>

<p>Reason for Request: <input checked="" type="checkbox"/> Treatment</p> <p>This Authorization expires in:</p> <p><input type="checkbox"/> 90 days <input type="checkbox"/> 120 days</p> <p><input type="checkbox"/> 1 Year</p> <p><input type="checkbox"/> Other date (not to exceed one year)</p>

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