1ST CHOICE HEALTHCARE
Revolving around you

Medical Records Authorization

Patient Name ____

SS# _________________________________DOB ______________

Address______________________________ City, ST, Zip______________________

Please fax/mail to following location:

PROVIDER REQUESTING RECORDS:

____T Bell ____Duncan ____Upshaw

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

____Hutchison ____Cazano _____ Fletcher ____Vinal

____Young ____Smith ____Murphy ____Upshaw

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

____Taber ____Cazano ____Upshaw

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

____Hart ____Murphy ____Privett ____Reagan ____D Guntharp ____Jansen ____Upshaw____Frier

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

____ Phillips ____Bell _____ Hodges ____Upshaw

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

_____Hunter ____ Edat ____Green ____Carter _____Reagan ____Throesch ____Upshaw____Gibson

____**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)

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