



Medical Records Authorization/Mental Health Release

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 ___ M 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:

<p>___ Office Notes dated _____ through _____</p> <p>___ Only items listed here:</p> <p>_____</p> <p>___ All Office notes in my chart, including test & consults as of the date of this authorization</p>	<p>Reason for Request:</p> <p>___ Treatment ___ Insurance ___ Personal Use</p> <p>This Authorization expires in:</p> <p>___ 90 days ___ 120 days</p> <p>___ 1 Year</p> <p>___ Other date (not to exceed one year)</p>
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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.

I HEARBY AUTHORIZE THIS INFORMATION TO BE RELEASED: ___ Verbally, ___ Written, ___ Electronic, ___ Faxed

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