



Patient Name \_\_\_\_\_

SS# \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ City, ST, Zip \_\_\_\_\_

**Please fax/mail to following location:  
PROVIDER REQUESTING RECORDS:**

\_\_\_\_ D King, APRN \_\_\_\_ H Tyler, APRN

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

\_\_\_\_ Dr Hutchison \_\_\_\_ DR Cazano \_\_\_\_ Dr McGath \_\_\_\_ M Martin, APRN \_\_\_\_ K Simmons

\_\_\_\_ J Young , APRN \_\_\_\_ Dr Smith \_\_\_\_ Dr Murphy \_\_\_\_ Dr Upshaw \_\_\_\_ Heather Phillips, LCSW

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

\_\_\_\_ A Taber, APRN \_\_\_\_ Dr Cazano \_\_\_\_ Dr Upshaw \_\_\_\_ Dr Yancey \_\_\_\_ C Burdin, APRN \_\_\_\_ Sonya Goode, LCSW

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

\_\_\_\_ B Mays, APRN \_\_\_\_ Dr Murphy \_\_\_\_ L Privett , APRN \_\_\_\_ J Reagan, APRN

\_\_\_\_ Dr Upshaw \_\_\_\_ T Frier, LCSW \_\_\_\_ Dr Mangroo \_\_\_\_ A Billingsley, APRN

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

\_\_\_\_ Dr Phillips \_\_\_\_ C Duncan, APRN \_\_\_\_ A Hodges, APRN \_\_\_\_ Dr Upshaw

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

\_\_\_\_ Dr Edat \_\_\_\_ D Guntharp, APRN \_\_\_\_ J Reagan, APRN \_\_\_\_ J Throesch, APRN

\_\_\_\_ Dr Upshaw \_\_\_\_ Dr Coates \_\_\_\_ K Slusser, APRN \_\_\_\_ Jessica Martin, LCSW \_\_\_\_ Dr Hunter

**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: <hr/> <input type="checkbox"/> All Office notes in my chart, including test & consults as of the date of this authorization
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<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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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