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:

____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

____J Young, APRN ____Dr Smith ____Dr Murphy ____Dr Upshaw____ H 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 ____S Goode, LCSW

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

____A Billingsley, APRN ____Dr Murphy ____ L Privett, APRN ____J Reagan, APRN

____ Dr Upshaw____ T Frier, LCSW____ Dr Mangroo ____ B Mays, 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 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.

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