6823 ISAAC'S ORCHARD RD
SPRINGDALE, AR 72762
479-750-2080 FAX 479-750-2082

AUTHORIZATION TO RELEASE HEALTH/MEDICAL INFORMATION

I hereby authorize: _____
(Doctor's Name or Medical Group)

Address: _____

_____

TO RELEASE ANY AND ALL RECORDS OR SUMMARY OF FINDINGS AND RECOMMENDATIONS.

Send Information to: _____

_____

_____

Regarding:

Patient's Name: _____

Date of Birth: _____

The authorization shall become effective immediately and shall expire six months from this date unless indicated otherwise or revoked earlier in writing. I understand that this information cannot be further released without my specific written consent.

_____ _____
Patient, Parent, Guardian, or Legal Representative Signature Date