Authorization for Release of Medical Records/Information

Cabot Medical Care
2037 West Main Street
Cabot, AR 72023
Phone: 501-843-4555 ● Fax: 501-743-1550

Patient Name: _____DOB:_____

Patient's Social Security #:_____ Phone #: _____

Street Address:_____

City, State and Zip Code:_____

I hereby authorize and request my records to be sent/release <u>FROM</u>:

Facility's Name:_____

Facility's Street Address:_____

Facility's City, State, and Zip Code:_____

I hereby authorize and request my records to be sent/released <u>TO</u>:

Facility's Name:_____

Facility's Street Address:_____

Facility's City, State, and Zip Code:_____

Send entire medical record _____ or Specific Medical Record _____

Specify what records are to be sent:_____

_____

Reason for Requesting Records: _____

(Changing doctors, moving, further care, legal, etc.)

*I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndromes (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol and drug abuse.

*Expiration: This authorization must be received within 90 days of the date of signature and will expire one year from the date of authorization, unless otherwise revoked by the patient.

*According to the AMS Physician's Legal Guide (5th Edition), page 168, physician's offices have 30 days from the date of the request to send medical records to patients who request them.

***If the requested records exceed 100 pages, there may be a fee. Also, if you are requesting records prior to 2012 you will encounter a slower process because this involves pulling a paper record from storage.**

_____ _____

(Patient's signature/patient's personal representative and relationship) (Date)

Last Updated: 3/27/2017