**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 #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address, City/State/Zip: \_\_\_\_\_\_\_\_

**I hereby authorize and request my records to be sent/release FROM:**

Facility / Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address, City/State/Zip: \_\_\_\_\_\_\_\_

Phone/Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I hereby authorize and request my records to be sent / released TO:**

Facility / Provider / Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address, City/State/Zip: \_\_\_\_\_\_\_\_

Phone/Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Entire Medical Record: If requesting entire medical record from Cabot Medical Care, this will only include records in our Electronic Medical Record system from 2012 to present. If you need dates prior to 2012, please specify here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Specific Medical Record: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Requesting:

Moving, changing doctors, legal, further care, 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)