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: (______) ______________________________

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

Facility / Provider / Patient Name: ____

Address, City/State/Zip: ____

Phone: (______) ___________________________ Fax: (______) ______________________________

Requesting to Obtain:

- o Entire Medical Record (this will only include records in our Electronic Medical Record system. If you need dates prior to 2012, please specify): ____
- o 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 (about 3 months) 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, physician's offices have 30 days (about 4 and a half weeks) 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)