ARKANSAS INTERNAL MEDICINE CLINIC, PA
500 SOUTH UNIVERISTY STE 605, LITTLE ROCK, AR 72205
Phone: 501-537-4590 Fax: 501-537-4591

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION TO THE PHYSICIAN ONLY

Patient's Name: _____
Social Security#: _____
Date of Birth: _____

I request and authorize _____to release health care information of the patient named above to:

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

- Health care Information relating to the following treatment, condition or dates: _____
- All Health Care Information
- Other: _____

Patient Signature: _____Date Signed _____

AUTHORIZATION TO RECEIVE HEALTH CARE INFORMATION TO THE PHYSICIAN ONLY

I herby request and authorize _____ to release all of my medical records to Dr. Solomon Mogbo located at 500 S. University Ste 605, Little Rock, AR 72205.

Please mail records to: 500 S. University Ste 605, Little Rock, AR 72205
Or you may fax them to: (501) 537-4591

If there are any questions regarding this request for medical records, please contact me at the address or phone number listed above.

Sincerely,

_____ _____
Patient Signature Date