ARKANSAS INTERNAL MEDICINE CLINIC, PA
1401 KANIS PARK DRIVE STE 200, 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: Arkansas Internal Medicine
Address: 1401 Kanis Park Drive Suite 200
City: Little Rock State: AR Zip Code: 72205

This request and authorization applies to:

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

This release is valid until dismissal from the practice (Arkansas Internal Medicine) and I have the right to revoke this release at anytime. If there are any questions regarding this request for medical records, please contact this facility at the address or phone number listed above.

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 Arkansas Internal Medicine Clinic located at 1401 Kanis Park Drive Ste 200, Little Rock, AR 72205.

Please mail records to: 1401 Kanis Park Drive Ste 200, Little Rock, AR 72205
Or you may fax them to: (501) 537-4591

This release is valid until dismissal from the practice (Arkansas Internal Medicine) and I have the right to revoke this release at anytime. If there are any questions regarding this request for medical records, please contact this facility at the address or phone number listed above.

Sincerely,

_____ _____
Patient Signature Date