Authorization for Release of Information

PROVIDERS PLEASE USE THIS SHEET AS YOUR COVER PAGE

I, ____, hereby authorize

____, to release to

Please give Full Name, Location &/or Telephone # of Person or Clinic to Provide Medical Records

the Murphy Clinic

1105 Deer Street Suite 13   Conway, AR 72032

Phone: (501) 766-4768   Fax: (855) 493-0851

Patient Information:

Name____ Birthdate__________________

Address____

Email Address____

Social Security Number______________________ Phone____________________________

Information Requested: __X__ Clinic Record/Note ________ Other __X__ Specified Below

Specific records pertaining to the diagnosis & treatment of__________________________

Covering the past _1-2 Office Visits Pertaining To Above Diagnosis &/or Treatment_______

Purpose of Release: ____X____ Medical Care ___________ Patient Request

Other (Specify) _**Medical Records Being Faxed Should Be Limited To 20 Pages Or Less**_____

This authorization will expire 90 days from the date on which it was signed unless I specify a different time period. I understand that I may revoke this authorization at any time by giving written notice. A revocation of this authorization will not apply to records already released in accordance with the authorization. A photocopy of this signed authorization shall constitute a valid authorization.

I understand that once the above information is disclosed, it may be re-disclosed by the designated Recipient and the information may no longer be protected by federal privacy laws and regulations.

Treatment, payment, enrollment of eligibility for benefits will not be conditioned on your signing this authorization.

Signature of Patient or Legal Representative______________________________**Date**_______________

If Legal Representative, authority of Legal Representative____

(Such as Parent, Guardian, Attorney-In-Fact Appointed with Power of Attorney or Healthcare Proxy)

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