Authorization for Release of Information

I, _____, hereby authorize

_____, to release to:

the Murphy Clinic

719 Front Street Conway, AR 72032
Phone: (501) 766-4768 Fax: (855) 493-0851

Patient Information:

Name_____ Birthdate_____

Address_____

Social Security Number_____ Phone_____

Information Requested: _____Clinic Record/Note _____ Other _____Specified Below
Specific records pertaining to the diagnosis & treatment of_____
Covering the past _____

Purpose of Release: _____ Medical Care _____ Patient Request

Other (Specify) _____

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)