Jacksonville Medical Care

Request for Release of Medical Records

RE: _____

(Patient Name) (Date of Birth) (Physician)

Date received: _____ Date completed: _____ Date picked up/mailed/faxed_____

ID Verified / Authorization verified: _____ Verified by phone: _____

Medical Records to be released from: _____

_____

_____

The specific information to be released is: _____

*Consent to release HIV/AIDS information (if applicable) requires patient initials: _____

For the purpose of: _____

Medical Records to be sent to: **Jacksonville Medical Care**

1300 Braden Street

P.O. Box 309

Jacksonville, AR 72076

(501) 985-5900

I have the right to revoke this Authorization at any time, provided that I do so in writing. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the facility receiving it and may no longer be protected under the federal privacy regulations.

I understand I may have to sign a new release each time medical records are requested.

SIGNATURE: _____ DATE: _____