King Medical Clinic

P.O. Box 397
180 Hwy 71 S.
Ashdown, AR 71822
Phone: (870) 898-5464
Fax: (870) 898-4606

Authorization for Release of Medical Records

Patient Name:____Date of Birth:_____________

Social Security Number:____Phone:______________________

I authorize release of my medical records FROM:

Physician/Facility		Phone/Fax
Address	City/ST	Zip

Please send my medical records TO:

Physician/Facility		Phone/Fax
Address	City/ST	Zip

Reason: _____Change of Insurance
_____ Transfer of Care
_____Personal File
_____Moving out of area
_____Specialist Consultation
_____Legal

Please release the following:

_____All Records
_____Lab Reports
_____Last 3 Visits
_____Immunizations
_____Recent H&P
_____Hospital Records
_____X-ray Reports
_____Other____________________
____

Please allow 30 days for processing. Incomplete information will delay processing. Use of this information for any other use than the state purpose is prohibited. This information is for the use of the designated recipient only and cannot be provided to any other agency. This release is valid from one year of date signed.

Signature of Patient or Guardian____**Date**_____________

Relationship to Patient____

Witness____**Date**_____________