ADULT MEDICINE CLINIC OF BLYTHEVILLE, P.C.
519 North 6th Street, Blytheville, AR 72315
Phone : (870) 762-5800, Fax : (870) 762-5801

Authorization for Release of Protected Health Information

Patient Name:______________________________ Date of Birth: ____________________

Address: __________________________________

City: _________________State: ____ Zip:______

Telephone No.:_____________________________

I hereby authorize ____to disclose my / my minor child's Protected Health Information to Adult Medicine Clinic of Blytheville, P.C. (its employees or its officers), 519 N. 6th Street, Blytheville, AR 72315

This information is needed for the following reason:

____

The specific information I wish to have released is (including dates of treatment):

____

I understand that I may revoke this consent at any time, except where information has already been released.

______________________________________ ______________________________
Signature: (Parent or Legal Guardian if Minor Child) Date:

This protected health information may contain information about drug abuse, alcoholism, alcohol abuse, venereal disease, abortion, or mental health treatment and I consent for all such release.