



403 West Oak St. Suite 204
El Dorado, AR 71730
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Medical Records Release Form

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone _____ Email: _____

Organization or Person to *Send* Records:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone _____ Fax: _____ Email: _____

Records Being Shared

- Complete Health Record
- Labs
- Imaging
- Other: _____

Organization or Person to *Receive* Records:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone _____ Fax: _____ Email: _____

Reason for Request

- Legal Case
- Insurance Claim
- Personal Records
- Continuing Care

Duration of Authorization

This authorization to share my health information is valid:

- From _____ to _____
- All past, present, and future periods

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

Organization: Surgical Office of Morgan & Kennedy
Address: 403 West Oak St, Suite 204 El Dorado, AR 71730

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.
- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Signature

Signature: _____ Date: _____

Print your name: _____

If this form is being completed by a person with legal authority to act on an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe below how this person has legal authority to sign this form:

