ARKANSAS

QUICK CARE

URGENT CARE AND WALK-IN CLINIC

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)

I hereby authorize_____and its physicians, employees and agents to release or disclose to the below-named recipient all of my medical records.

Patient Name: _____ Date of Birth: _____

I hereby authorize the release of medical records to: Arkansas Quick Care

_____

This request and authorization applies to:

_____ All medical records

_____ Health care information relating to the following treatment, condition, or dates of treatment:

_____

_____ Specific records to be released (eg. Labs, imaging reports, other):

_____

_____ _____

Signature of Patient or Authorized Representative Date Signed

_____

Relationship to Patient

Arkansas Quick Care, 1101 N James St. Jacksonville, AR 72076
Phone: 501.241.1919, Fax: 501.457.8020

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