Saline Heart Group, P.A.

Medical Record Release Form

Date: _____

Patient: _____

Date of Birth: _____

The person named above authorizes information to be released by or released to:

Saline Heart Group
1000 Hwy 35 N, Ste 8
Benton, AR 72019
Phone: 501-315-4008
Fax: 501-315-3411

Name of Person, Provider, or Facility: _____

Address: _____

Phone: _____ Fax: _____

Please check information requested:

_____ Information regarding assessment, diagnosis, and treatment of patient's condition, concern, or disease (**including** alcohol or drug use/abuse treatment, mental health treatment, HIV status or treatment)

_____ All
_____ Care received between the dates of _____ and _____
_____ Specific information: _____

OR

_____ Information regarding assessment, diagnosis, and treatment of patient's condition, concern, or disease (**excluding** alcohol or drug use/abuse treatment, mental health treatment, HIV status or treatment)

_____ All
_____ Care received between the dates of _____ and _____
_____ Specific information: _____

Patient Signature / Authorization Signature: _____

If not signed by the patient, indicate relationship of authorizing person to patient:
_____ Guardian or Power of Attorney of conserved patient
_____ Beneficiary of deceased individual