

Arkansas Medical Foundation

for

The Physicians Health Committee

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ (Date of Birth ____ / ____ / ____) hereby authorize:
Participant Full Name

Arkansas Medical Foundation
10 Corporate Hill Drive, Suite 150
Little Rock, AR 72205

To exchange (receive and share) information with the individual/organization listed below for the purpose of program compliance and ongoing patient care.

Name

Organization

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Zip

(____) _____
Phone No.

(____) _____
Fax No.

Email

Printed Name

Signature

Date

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