Date:_____

Patient's Name: _____.

Date of Birth: _____.

I hereby authorize; Reeves Medical Associates PLLC,
1415 E Centerton Blvd, Centerton AR 72719
Email form to staff@reevesmed.com

____To release my medical record for the last year.
____To release my medical record since 2018 or start of care at ReevesMed.
____To release my lab and radiology records only.

Going to : Name: _____
Address: _____
_____
Phone: _____
Fax: _____

Signed:_____ Date: _____

Authorized Representative: _____ Date: _____

*Minor Only
Guardian: _____ Date: _____