AUTHORIZATION TO RELEASE MEDICAL RECORDS FOR ARKANSAS PATIENTS OF DR FRAZIER

RELEASE RECORDS FROM:
CYNTHIA FRAZIER MD
A Clinic for Women
Little Rock, AR

PATIENT NAME____ DOB____________________

ADDRESS____

CITY STATE ZIP____

PATIENT EMAIL______________________________SIGNATURE______________________________

DATE________________________________

IF UNDER 18 GUARDIAN SIGNATURE REQUIRED

SIGNATURE____ DATE_______________________________

RELEASE RECORDS TO:

NAME____

ADDRESS____

PHONE____

SIGN AND DATE THE AUTHORIZATION AND MAIL TO:
CYNTHIA FRAZIER MD
1125 N. Howe St.
Southport NC 28461, or scan and email to:
info@drcynthiafrazier.com
I will combine your paper and electronic records on a CD and mail one copy to you at no charge. Please include your email and I will send you a note when I mail the CD.