ARKANSAS STATE MEDICAL BOARD

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Please complete all areas of the bottom portion of this form and fax to (501) 603-3555

AUTHORIZATION AND RELEASE

To Whom It May Concern:

This document will authorize and direct any physicians with whom I have been associated, employees and medical staff members of any medical facility or hospital where I have been employed or on staff or associated, or any employees of any malpractice insurance carriers, or any state medical licensing boards where I have been licensed or have applied for a license, or any medical clinics where I have been employed or associated, or any medical schools where I have attended, to give to, copy for, or permit the personal inspection by employees or representatives of the Arkansas State Medical Board of any and all personnel records, disciplinary records, work records, military records, professional performance reviews, evaluations of my performances.

I hereby release and discharge you and any other individuals or organizations referred to in this Authorization, and release you of any confidentiality requirements that might bind you, so that you may carry out the purposes of this document.

A copy of this document* may be provided to entities listed above, and this Authorization shall remain in effect for a period not to exceed two (2) years or until specifically revoked by me in writing.

Typed or Printed Name of Physician: _____

Social Security Number: _____

Signature of Physician (**Black or Blue Ink Only**): _____ Date: _____
(Do not use signature stamps)

**** This document does not authorize the Arkansas Medical Board to release information collected to third parties except as later authorized by the above physician and Arkansas law.***