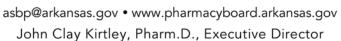


I Authorize:

## Arkansas State Board of Pharmacy

322 South Main Street, Suite 600 Little Rock, AR 72201 P: 501.682.0190 F: 501.682.0195





## Release of Medical/Treatment Records Authorization for Use and Disclosure of Protected Health Information

	Facility Name:		
Mailing Address:			
City, State, Zip:			
Phone Number:			
To Release Information to:		Arkansas State Boar 322 South Main Stre Little Rock, AR 7220	et, Suite 600
The f	ollowing about me can b	e released:	
×	All Clinical records, including any records transferred from other medical/treatment facilities, doctor/therapist notes, and progress notes.		
	Other:		
Purpose of this authorization: Licensure with the Arkansas State Board of Pharmacy.  Records must come directly from the treating physician/facility.			
	* A COPY OF	THIS FORM IS AS	EFFECTIVE AS THE ORIGINAL. *
Patient's Printed Name			Patient's Date of Birth
Patient's Signature			Date Signed