Authorization to Release Medical Information
THE WINSTON CLINIC P.A., P.O. Box 100, Sheridan, AR 72150
Phone: (870)942-3000 Fax: (870)942-3005

I authorize the health care provider named below to release all medical records upon request to The Winston Clinic, P.A. to the address above at the time of the request.

☐ S. Winston, M.D. ☐ L. Garner, NP ☐ B. HENSLEY, NP

☐ D. Dixon, PA-C ☐ J. Garner, NP ☐ L. HENSLEY, NP ☐ A.COVERT,NP

Provider Name/Clinic: _____

Address: _____

Phone #: _____ **Fax #:** _____

Patient's Name: _____

Social Security #: _____ **DOB:** _____

Address: _____

Signature: _____ **Date:** _____

If not signed by the patient, please indicate relationship:

☐ Parent or Guardian of minor patient

☐ Guardian or conservator of an Incompetent patient

☐ Beneficiary or personal representative of deceased patient