REFERRAL FORM

Little Rock Walk in Clinic

802 N University, Little Rock, AR

Phone: (501) 291-2322 Fax: (888) 388-5166

Date: 12-22-2020

Holland Jay

I have performed a clinical assessment of the patient named below, Whom I am referring for:

kjklj

Please advise me, as appropriate, of your medical findings and diagnosis, treatment plan and/or services you provide subsequent to this referral. Please note that services beyond the scope of this referral require a new referral. Referral for ongoing services require renewal atleast every 6 months.

Jay Holland
12-22-2020

Provider Number:
Phone: (501) 664-0769

Confidential Health Information is attached. This Health Care Information is Personal & Sensitive. It is being shared with you after the appropriate authorization from the patient or under circumstances that do not require individual authorization. You, the recipient is obligated to maintain this information in a safe, secure & confidential manner. Re-disclosure without appropriate additional consent or authorization of the individual or as permitted by the law is prohibited. Unauthorized re-disclosure or failure to maintain the confidentiality of this information could subject you to penalties under the Federal and/or State Laws.

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