



Dear FCCOA Patient,

Thank you for trusting Family Care Centers of America with your care. We know that you have options when choosing your medical provider and it is an important decision. We are incredibly grateful that you chose our team and we take this role with the greatest level of responsibility.

Unfortunately, I regret to inform you that Family Care Centers of America located at 1600 S. Colorado St., Greenville, MS 38703 will be closing effective October 22nd, 2026. You will need to transfer your care to another provider as soon as possible. A list of community providers is attached to this letter. Family Care Centers of America will remain available to consult with your new provider to ensure a smooth transition and continuity of care until October 22nd, 2026.

This closure does not affect Pain Treatment Centers of America. If you are a PTCOA patient, you will still see your provider at your scheduled appointment time.

Please rest assured that your medical records will remain confidential and on file with Family Care Centers of America. Please contact our Medical Records department at (844) 215-0731 to complete a Release of PHI form. For your convenience, we have also attached the Release of PHI to this letter. After October 22nd, 2026, requests for medical records can be directed to:

Family Care Centers of America

Attn: Medical Records

108 N. Shackleford Rd.

Little Rock, AR 72211

Phone: (844) 215-0731

Fax: (501) 476-5707

If you have not selected a new provider by October 22nd, 2026, you may obtain acute, critical, or emergency care at Delta Regional Medical Center, Phone: (662) 378-3783.

We are honored to have been part of your treatment team. If you have any additional questions, please call (844) 215-0731.

Sincerely,

A handwritten signature in black ink, appearing to read "Holly Cameron", is written over a horizontal line.

Holly Cameron, RN

Vice President of Clinical Services



Community Providers

Joe Pulliam, MD

1467 MS-1 S

Greenville, MS 38701

Phone: (662) 335-1621

Neal Suares MD, Family Medicine Clinic

1554 S. Colorado St.

Greenville, MS 38703

Phone: (662) 334-8557

Greenville Family Clinic

867 MS-1

Greenville, MS 38701

Phone:(662) 378-0283

Potter Family Medical

1462 MS-1

Greenville, MS 38701

Phone: (662) 702-5121

1. I, _____, authorize FCCA to disclose certain protected health information to:
Name/Facility: _____
Address: _____
Phone: _____ Fax: _____
2. Patient whose information is to be disclosed:
Name: _____ Date of Birth: _____
Email Address: _____
3. Specific information to be accessed or released:
☐ Complete Medical Record, including records of other providers on file with FCCA, if any.
☐ Information limited to the following dates of treatment: _____
☐ History & Physical
☐ Diagnosis
☐ Laboratory Reports
☐ Pathology Reports
☐ Radiology Reports
☐ X-rays, ultrasounds, and any other images, only if specifically requested by designated recipient.
☐ Billing Records
☐ Other: _____
4. The purpose of this disclosure is:
☐ Continuity of Care (no charge)
☐ Insurance
☐ Legal Reasons
☐ Personal Records
☐ At the request of the patient
☐ Other: _____
5. This authorization (check one):
☐ Will not expire unless it is revoked in writing
☐ Will expire when the following event or date occurs: _____
6. I understand that my medical records are available to me without charge on the FCCA patient portal.
I understand that I must prepay in advance for additional copies of the specific records detailed in #3 to be:
☐ Forwarded by email to a third party - \$6.50
☐ Printed/mailed to a third party - \$12.00
7. Preferred format:
☐ Paper copies
☐ CD-ROM or electronic file format
8. Method of delivery:
☐ Pick-up at facility
☐ Mail to address listed above
☐ Mail to address/facility at: _____

9. I understand that if the records requested contain information on sexually transmitted disease, HIV, AIDS or related conditions, other communicable diseases, genetics, alcohol abuse, drug abuse, or psychiatric or psychological conditions (except psychotherapy notes), that this authorization includes that information.

10. I understand I have the right at any time to revoke this authorization in writing except to the extent that FCCA has already acted in reliance on it. I understand my written revocation must be submitted to FCCA and will become part of my medical record.

11. I realize that when the above information is disclosed, it may be re-disclosed by the recipient, and there is no guarantee that it will continue to be protected by the federal HIPAA Privacy Rule.

12. A photocopy of this authorization is as valid as the original.

13. I understand that FCCA will not condition treatment, payment for healthcare services, enrollment, or eligibility for healthcare benefits on signing this authorization.

14. I release FCCA, its employees and physicians from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

15. I understand that if I am the patient's parent, legal representative, or guardian, I am responsible for the release of information with regard to the above named patient and must provide appropriate documentation authorizing the release of information.

Signature of Patient or Parent/Legal Representative

Date

Patient Name (Printed)

Name of Parent/Legal Representative*, if applicable (Printed)

*If signed by Legal Representative, please attach copy of power of attorney, court records, or other documents establishing legal authority to act for Patient (e.g., personal representative for estate).

For HIM Office Use Only

Identification:

____ Driver's License: _____ State ID: _____ Military ID: _____

If signed by a Legal Representative, indicate authority and documentation submitted:

____ Death Certificate ____ Power of Attorney ____ Court Order ____ Letters of Guardianship

____ Other: _____

Processed by: _____ Date: _____ Mailed/Faxed/Given by: _____

Comments: _____
