



- Benton
- Clinton
- Conway
- El Dorado
- Heber Springs
- Little Rock
- Mountain Home
- North Little Rock
- Russellville
- Searcy
- Stuttgart

# Authorization to Release Protected Health Information

MRN# \_\_\_\_\_

Patient Name \_\_\_\_\_ Formerly Known As \_\_\_\_\_ Birth Date \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # \_\_\_\_\_

PURPOSE OF REQUEST  Continuation of Care  Personal  Legal  Insurance  Other \_\_\_\_\_

I authorize release to \_\_\_\_\_ Phone # \_\_\_\_\_

Name/Facility \_\_\_\_\_ Fax # \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Date of service range (month/year): From \_\_\_\_\_ To \_\_\_\_\_

### INFORMATION TO BE RELEASED

- History and Physical
- Billing Information
- Clinic/Progress Notes
- Complete (All records, notes, meds, flowsheets, etc.)
- Consultations/Evaluations
- Med Onc Treatment Records
- Pathology Reports
- Operative Reports
- Laboratory Reports

- Radiology Reports
- Media-free DICOM format image data
- Radiology Images
- Rad Onc Treatment Records
- Discharge/End of Treatment Summary
- Other: \_\_\_\_\_

I request this authorization to expire on \_\_\_\_\_ or one (1) year from the date signed below and covers only treatment for the dates specified above.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

1. Requests will be processed within 28 calendar days.
2. I authorize the release of my medical record, including photographs.
3. This authorization is voluntary and the disclosure is made at my request.
4. If the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
5. Multiple requests are authorized if the purpose of the request remains the same.
6. I have a right to revoke this authorization at any time and if I revoke this authorization, I must do so in writing and present the written revocation to the department that I have authorized to release the information. Any revocation will not apply to information that has already been released in response to this authorization.
7. I need not sign this form to ensure health care treatment.

Additionally, a radiological CD-ROM can be provided at no cost to a patient for a physician or facility referral.

Paper copies  CD-ROM Method of Delivery:  Pick-up at facility  Mail to address listed above

Mail to alt address/facility: \_\_\_\_\_

**IMPORTANT WARNING:** The documents accompanying this message are intended for the use of the person or entity to which this message is addressed. These documents may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law. If you are the employee or agent responsible to deliver this information to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is **STRICTLY PROHIBITED**.

#### For HIM Office Use Only

ID:  Driver's License \_\_\_\_\_  State ID \_\_\_\_\_  Military ID \_\_\_\_\_

If signed by legal representative, indicate documentation:  Death Certificate  Power of Attorney  Living Will

Processed by: \_\_\_\_\_ Date \_\_\_\_\_ Mailed/Faxed/Given by \_\_\_\_\_