



**AUTHORIZATION
FOR RELEASE OF
PROTECTED
HEALTHCARE
INFORMATION**

**200 N. 3rd Street
ATTN: Medical Records
Dardanelle, AR 72834
Phone: 479-229-4677**

All portions of this form must be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

Patient's Name	Date of Birth	Medical Record Number
Address	City	State
	Zip	Telephone Number
Email Address		

I authorize the use and disclosure of health information about me as described below:

Facility Authorized to Release my Health Information

Agency or Individual(s) Authorized to Receive my Health Information

Address	City	State	Zip	Telephone Number
---------	------	-------	-----	------------------

Health information that may be used / disclosed is limited to the following:

<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Consultation(s)	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Emergency Room Record
<input type="checkbox"/> Operative Note(s)	<input type="checkbox"/> Imaging / X-Ray	<input type="checkbox"/> X-Ray Reports	<input type="checkbox"/> Lab	<input type="checkbox"/> Pathology Report
<input type="checkbox"/> Other (<i>specify</i>) _____		<input type="checkbox"/> Entire Record		

Health information that may be used / disclosed is limited to the following periods of healthcare:

From (date): _____ To (date): _____ Account Number: _____

From (date): _____ To (date): _____ Account Number: _____

Health information to be released to the above named agency / individual is to be used / disclosed for the following purpose(s):

<input type="checkbox"/> Treatment/Consultation	<input type="checkbox"/> At Request of Patient	<input type="checkbox"/> Research	<input type="checkbox"/> Marketing	<input type="checkbox"/> Billing or Claims Payment
<input type="checkbox"/> At Request of Employer				
<input type="checkbox"/> Other _____				

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, X-Ray films, slides, tracings, strips, etc.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, **to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses** compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

Yes No *If applicable* I agree to the release of my medical or billing records containing sensitive information listed above.

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

This authorization will automatically expire 180 days after the date of signature below (except as indicated below), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the HIPAA prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

Copy to the individual: If a covered entity seeks an authorization from an individual for a use or disclosure of protected health information, the covered entity must provide the individual with a copy of the signed authorization.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with (HIPAA) privacy regulations.

Patient's or Authorized Personal Representative's Signature*		Date	Time
Relationship to Patient / Authority to Act on Patient's Behalf		Interpreter, If Used	
Patient's or Authorized Personal Representative's Signature*	Date	Time	Expiration Date or Event

*Signature validated against driver's license or signature in Medical Record. There may be a charge for copying Medical Records.

Electronic copy requested.