North Arkansas Regional Medical Center
620 N. Willow • Harrison, AR 72601 • (870) 365-2000

Authorization to Release Medical Information

(PLEASE PRINT)

Patient Name _____ Social Security Number: _____

Medical Record Number: _____ Date of Service: _____ Date of Birth: _____

1. I authorize the release of the above-named individual's medical records as described below:
2. The following organization is authorized to make the disclosure: NARMC and subsidiary agencies
   ❑ Marshall Family Practice ❑ Claude Parrish Health Clinic ❑ Newton Co. Family Practice
   ❑ Other: _____
3. The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated):
   ❑ Face Sheet ❑ History & Physical ❑ EKG ❑ Pathology
   ❑ Discharge Summary ❑ Lab Report ❑ Consultation ❑ Doctor's Orders
   ❑ ER Record ❑ Radiology Report ❑ Surgery Report ❑ Progress Notes
   ❑ Other (please describe): _____ ❑ Medication Record
4. I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. The information identified above may be used by or disclosed to the following individuals or organization(s):
   Facility-Clinician-Person: _____
   Address: _____
   City, State: _____ Phone Number: _____
6. This information for which I am authorizing disclosure will be used for the following purpose:
   ❑ Personal Use ❑ Continued Care ❑ Legal Purposes ❑ Insurance Purposes
   ❑ Other: _____
7. I understand that I have a right to withdraw this authorization at any time. I understand that if I withdraw this authorization, I must do so in writing and give my written withdrawal to the Medical Records Department. I understand that stopping this release will not apply to information that has already been released by this authorization. I understand that the withdrawal will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
8. This authorization will expire _____ (insert date or event). If I fail to specify an expiration date or event, this authorization will expire 90 days from the date on which it was signed.
9. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
10. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used or disclosed under this authorization.
11. I understand that North Arkansas Regional Medical Center may be paid for the costs of copying the information to be disclosed.

_____ _____
Signature Date

_____ _____
OR Signature of parent, guardian or authorized representative Nature of Relationship

_____ _____
Witness Signature Date

FOR HOSPITAL USE ONLY:

❑ Verified identity (ex: copy of driver's license, check signature, etc.)

Comments: _____

_____

Hospital Personnel: _____

❑ Picked up (who) _____

❑ Mailed ❑ Faxed

❑ Other: _____

Date: _____

(Please give a copy of the completed release to the patient and send a copy with requested information)

Form #8672