North Arkansas REGIONAL MEDICAL CENTER

Authorization to Release Medical Information

(PLEASE PRINT)

* 8 6 7 2 *

Patient Name: _____ Social Security Number (Last 4 digits): XXX-XX-_____

Patient Address: _____ City: _____ State: _____ Zip code: _____

Patient Phone: _____ Date of Birth: ___/___/_____ Email: _____

I request my Protected Health Information (PHI) to be released FROM:

☐North Arkansas Regional Medical Center ☐NARMC Clinics

I request my Protected Health Information (PHI) to be released TO:

Recipient Name: _____

Address: _____

City, State: _____ Phone Number: _____

If Healthcare Provider, Fax #: _____ email: _____

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 ☐Imaging Disk ☐Discharge Summary
☐Lab Report ☐Consultation ☐ER Record ☐PT/OT/SP ☐Progress Notes
☐Radiology Report ☐Surgery Report ☐Itemized Billing ☐Complete Billing ☐Complete Medical Record
☐Other (please describe): _____

Period of healthcare covered: Specific date _____ to _____

The information for which I am authorizing disclosure will be used for the following purpose:

☐Personal Use ☐Continued Care ☐Legal Purposes ☐Insurance Purposes ☐Other: _____

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.

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 withdrawing this release will not apply to information that has already been released by its 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.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulation.

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 of benefits. I may inspect or obtain a copy of any information used or disclosed under this authorization.

I understand that North Arkansas Regional Medical Center may be paid for the costs of copying the information to be disclosed.

This authorization will expire _____ (insert date or event). If I fail to specify an expiration date or event, this authorization will expire 1 year from the date on which it was signed.

_____ _____
Signature Date

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

_____ _____
Witness Signature Date

* If signed by a patient's authorized representative, supporting legal documentation must accompany this authorization form

---

FOR OFFICE USE ONLY:

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

Comments: _____

_____

Office 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)