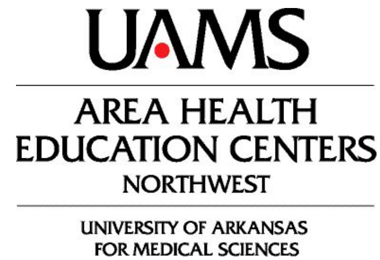
Family Medical Center
1125 North College
Fayetteville, AR 72703
(479) 521-8269
(479) 443-3903 (FAX)

- A COPY OF THIS FORM MUST ACCOMPANY RECORDS TO ABOVE ADDRESS



Authorization for Access To and Release of Information

1. I, ____, hereby authorize Northwest Family Medical Center to release to/request from:

   Name/Facility ____ Phone: ____________________

   Complete Address ____

2. Information of:
   Patient Name ____

   Birth Date and/or Soc. Sec. No. ______________________________ Phone ____________________

   Medical Record Number (if known) ____

3. Information requested to be accessed or released:

   _____ Abstract _____ Operative Report _____ ER Record _____ History & Physical

   _____ Discharge Summary _____ Clinic Record _____ Billing _____ Admission Record

   _____ All Northwest Family Medical Center Records _____Other______________________________

   _____ **Records of Other Providers maintained by NWFMC (if any)** (We must impose our standard copying fees as stated below. NWFMC does not represent that these records are the complete records of the other providers. If you want a complete copy of the records created by the other providers for this patient, you may wish to contact those other providers.

4. Information is to be limited to the following Dates of Treatment (if applicable):

5. Purpose of access or release:

   _____ Medical Care _____ Insurance or Other Payment

   _____ At the Request of the Patient _____ Other ______________________________

6. This authorization will expire one (1) year from the date on which it was signed unless I specify a shorter time period. Expiration Date: ____________________. However, I understand that this authorization may be revoked at any time by giving written notice to the facility. A revocation of this authorization will not apply to records already released in reliance upon the authorization. A photocopy of this signed authorization shall constitute a valid authorization.

7. The facility, its employees and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

8. I understand that once the above information is disclosed, it may be re-disclosed by the designed recipient and the information may not be protected by Federal privacy laws and regulations.

9. I agree to pay the costs of copying, supplies, labor, postage and other expenses associated with this request as allowed by law.

Patient or Personal Representative ____ Date: ______________

If Personal Representative, authority of Personal Representative ____

Witness ____________________________________ Date:____