UAMS
UNIVERSITY OF ARKANSAS
FOR MEDICAL SCIENCES

# Authorization for Release of Information

1. I, _____, hereby authorize AHEC-FS to release to:

   Name_____Phone_____

   Address_____

2. Information of:
   Patient Name_____ Date of Birth:_____

   Social Security No._____ Phone:_____

3. Information is to be limited to the following **Dates of Treatment:** _____

4. Information requested to be released:

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

   _____ Clinic Record _____ Admission Record _____ Physicians' Progress Notes _____ Nurses' Progress Notes

   _____ Other _____

   _____ Records of Other Providers on File With AHEC-FS (if any) *(We must impose our standard copying fees as stated below. UAMS 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 each provider.)*

I understand that **if** the records requested to be released include information relating to **sexually transmitted disease, AIDS or HIV, alcohol or drug use, or mental health information**, this information may be released pursuant to this authorization.

5. Purpose of access or release: _____ Medical Care _____ Insurance or Other Payment _____ At Request of the Patient
   _____ Other (explain): _____

6. This authorization will expire 90 days from the date on which it was signed unless I specify a shorter time period. Expiration Date: _____. I understand that I may revoke this authorization at any time by giving written notice to AHEC-FS, except that 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. AHEC-FS, 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 designated recipient and the information may no longer be protected by Federal privacy laws and regulations.

9. I agree to pay the copying cost, including other expenses allowed by law, such as the cost of any supplies, labor of copying, postage, or other expenses incurred by AHEC-FS to provide the copies requested.

10. AHEC-FS will not condition treatment, payment, enrollment or eligibility for benefits on your signing of this authorization.

Signature of Patient or Legal Representative _____ Date: _____

**If Legal Representative**, authority of Legal Representative _____
(such as parent, guardian, administrator of estate of deceased, attorney-in-fact appointed with power of attorney, or healthcare proxy)