AHEC Southwest Family Practice
300 East 6th Street
Texarkana AR 71854
(870) 779-6000 Office / (870) 779-6055 Fax

Authorization for Release of Information to UAMS

1. I, _____, hereby authorize UAMS to release to:

   Name_____ Phone _____ Fax _____

   Complete Address _____
   Street Address City State Zip

2. Information of:
   Patient Name_____ Medical Record No. (if known) _____
   Date of Birth and/or Social Security No._____ Patient Phone _____

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

4. Information requested to be accessed or 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 UAMS (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 abuse, or mental health information**, this information may be released pursuant to this authorization.

5. _____ Billing Records. For clinic or hospital billing records, please contact Patient Account Services at (870) 779-6000.

6. Purpose of access or release is at the request of the patient **or**: _____ Medical Care _____ Insurance or Other Payment _____ Other (explain): _____

7. This authorization will expire 90 days from the date on which it was signed unless I specify a different time period. Expiration Date or Event: _____. I understand that I may revoke this authorization at any time by giving written notice to UAMS. 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.

8. UAMS, 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.

9. 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.

10. 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 expense incurred by UAMS to provide the copies requested.

11. UAMS 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 of minor, court-appointed guardian, administrator of estate of deceased, attorney-in-fact appointed with power of attorney, or health care proxy)

EPF Barcode HIPAA **PROVIDE COPY TO PATIENT/LEGAL REPRESENTATIVE**
Med Rec 99 FR (0407)