UAMS Family Medical Center-Springdale
601 West Maple Ave., Suite 102
Springdale, AR 72764
(479) 750-6585
(479) 872-0040 (FAX)

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

UAMS
NORTHWEST
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

Authorization for Release of Information To UAMS-FMC

1. I, _____, hereby authorize:

   Name/Facility _____

   Complete Address _____

   Phone _____ Fax _____

2. To release to: UAMS Family Medical Center
   601 West Maple Ave, Suite 102
   Springdale, AR 72764
   Phone: 479-750-6585
   Fax: 479-872-0040

3. Information of:
   Patient Name _____
   Birth Date and/or Soc. Sec. No. _____ Phone _____
   Medical Record Number (if known) _____

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

5. Information requested to be accessed or released:

   _____ Abstract ____ Operative Report _____ ER Record _____ History & Physical
   _____ Discharge Summary ____ Clinic Record _____ Billing _____ Admission Record
   _____ Other _____

6. Purpose of release is at the request of the patient **or**: _____ Insurance or Other Payment
   _____Medical Care _____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 NWFMC. 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. 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. Treatment, payment, enrollment or eligibility for benefits will not be conditioned on your signing this authorization.

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Signature of Patient or Legal Representative _____ Date: _____

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

PROVIDE COPY TO PATIENT/LEGAL REPRESENTATIVE

UAMS Family Medical Center-Springdale
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Authorization for Release of Information from UAMS-FMC

1. I, _____, hereby authorize UAMS Family Medical Center to release to:
   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 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 _____ Billing _____ Admission Record
   _____ Other _____

   ____ Records of Other Providers on File with UAMS-FMC (if any) (We must impose our standard copying fees as stated below. UAMS-FMC 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. Dates: _____
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-FMC. 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-FMC, 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-FMC to provide the copies requested.
11. UAMS-FMC 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 Personal Representative _____
(such as parent of a minor, court-appointed guardian, administrator of estate of deceased, attorney-in-fact appointed with power of attorney, or healthcare proxy)

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