1660 West C Place
Russellville, AR 72801
479-219-5008

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENTS NAME_____ DATE OF BIRTH_____

Please print name, address and phone number from whom records are being requested.

FROM:_____ PHONE: _____

For the following reason(s): _____

Designate instructions by checking one of the following:

_____Entire medical record **including** information related to the treatment of substance abuse or dependency, mental health treatment and information relating to testing or treatment of sexually transmitted diseases and HIV/AIDS.

_____ Entire medical record **excluding** information related to the treatment of substance abuse or dependency, mental health treatment and information relating to testing or treatment of sexually transmitted diseases and HIV/AIDS.

_____ Record care from_____to_____**including** information related to the treatment of substance abuse or dependency, mental health treatment and information relating to testing or treatment of sexually transmitted disease and HIV/AIDS.

_____ Record care from_____to_____**excluding** information related to the treatment of substance abuse or dependency mental health treatment and information relating to testing or treatment of sexually transmitted disease and HIV/AIDS.

_____Other as stated: _____

CONDITIONS:

- The patient agrees to authorize the above-named individuals/organizations to access his/her confidential healthcare information only for purposes listed above
- The patient has the right to a copy of the confidential healthcare information for which this authorization is being sought
- The practice may not condition treatment or payment on whether the patient signs this authorization
- The patient authorizes the information to be disclosed by fax transmission, if necessary
- The patient is voluntarily signing this authorization
- The patient reserves the right to refuse to sign this authorization
- The patient reserves the right to revoke this authorization at any time in writing
- The patient has the right to receive a copy of the signed authorization

I authorize records to be released as indicated above. I understand that this release is in effect for one year from date of signature, but I may revoke my consent at any time by providing written revocation to the facility releasing the information.

SIGNATURE:
Patient/Legal Representative: _____ Date: _____