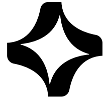
Authorization for Release of Health Information



PATIENT INFORMATION

First Name | **Last Name** | **Date of Birth**

Street Address

City/State | Zip | Phone Number

INFORMATION REQUESTED

I request the following information to be released, which may include: alcohol/drug treatment; HIV, AIDS or ARC; communicable disease or infections, including sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis; genetic information and demographic information; reproductive health records of a minor *(minors signature required)*.

Please indicate the specific type of information to be disclosed. ("All records" or incomplete dates are not considered specific.) **Charges may apply. Please contact us for details. Cash payments are not accepted.**

Department/Physician/Clinic Location:

☐ Complete Medical Records ☐ Progress/Physicians Notes ☐ Radiology Reports

☐ Radiology Images (CD) ☐ Lab/Path Reports ☐ Operative/Procedure Reports

☐ Cardiology/EKG Reports ☐ Immunizations ☐ Billing Statement

☐ Other: Date range of Treatment:

RECIPIENT

☐ **I want records sent TO Arcare**

I authorize ______________________ to release the above patient records to Arcare.

Arcare Address: Fax Number:

☐ **I want records sent FROM Arcare**

I authorize Arcare, its clinical subsidiaries and DBAs, to release the above patient records to:

Name/Organization: ______________________

Address: Phone/Fax:

METHOD OF DELIVERY

☐ Fax ☐ U.S. Mail ☐ Secure e-Delivery

Email Address: ____________________

PURPOSE OF DISCLOSURE

☐ Continuation of Care ☐ Personal Reasons ☐ Insurance ☐ Legal

☐ Transfer of Care (Permanently Leaving) ☐ Other: ____________________

I understand I have the right to revoke this authorization in writing at any time by sending revocation to the Compliance Department at 200 W. Race Ave, Searcy AR, 72143 or email complianceandquality@arcare.net. The revocation will not apply if Arcare has already acted in reliance on the authorization.

I understand that I am authorizing Arcare to make the disclosure of patient's health information in accordance with and in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand this authorization will expire in 90 days or upon the following specified date or event:

____

I understand information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by law.

I understand I have the right to inspect/receive a copy of the information used/disclosed and receive a copy of this form.

I understand that disclosure will include Mental Health, HIV/AIDS/STD, Genetic Testing, and Drug/Alcohol Abuse information (refer to Section 2 above).

I understand I have the right to refuse to sign this authorization, and Arcare does not condition treatment on this authorization, except disclosure necessary for payment of claims (excluding psychotherapy notes) or provision of healthcare solely for the purpose of creating PHI for disclosure to a third party (i.e., pre-employment or life insurance physicals).

I hereby acknowledge I have read and fully understand the statements and consent to the release of records.

Signature of patient or adult consenting for a patient	Relationship to patient	Date

Notice to receiving agency or individual: This information is to be treated in accordance with HIPAA privacy regulations.