Arkansas Psychiatric Clinic

#4 Executive Center Ct. Little Rock, AR 72211

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, _____hereby authorize the disclosure of information from my health record.
(PRINT NAME)

DOB:_____/_____/_____ SS#:_____-_____-_____

I. The information is to be disclosed **FROM:** And to be provided **TO**:

NAME OF FACILITY:	NAME OF RECIPIENT:
ADDRESS:	ADDRESS:
CITY/STATE:	CITY/STATE:
PHONE NUMBER:	PHONE NUMBER:
FAX NUMBER:	FAX NUMBER:

☐ ***** I acknowledge I will pay costs associated with the copies of my medical records before they are released to myself.**

II. The purpose(s) or need for this disclosure is:

☐ Medical care ☐ Attorney ☐ School ☐ Insurance Use ☐ Personal Use ☐ Disability
☐ Other:_____

III. The information to be disclosed from my health record (*check appropriate box(es)*).

☐Discharge Summary	☐Outpatient Clinic Records	☐Complete Medical Record
☐Inpatient Progress Notes	☐Psychotherapy Notes	☐Other:
☐Laboratory Test(s)	☐Psychiatric Notes	

With Provider(s) _____ during the time of period of event(s) from _____ to _____.

IV. **Expiration: This authorization shall become effective immediately and shall remain in effect until (enter specific date) _____. If no date is given, the authorization shall be valid for one year from the date of signing.*

V. *Rights: I understand: I have the right to revoke this Authorization by written request at any time; my revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my Authorization was valid; my records may be subject to re-disclosure by recipient(s) and unprotected by Federal or State law; I may inspect a copy of my Protected Health Information to be used or disclosed under this Authorization; I may refuse to sign this Authorization and my refusal will not affect my eligibility for care or condition treatment; and a copy of this signed, dated Authorization shall be effective as the original.*

_____ _____
Signature of Patient/Guardian **Date**

_____ _____
Witness (office staff) Signature **Date**

***Additional Information:

GUARDIAN or POWER OF ATTORNEY:	DATE OF BIRTH:
RELATION TO PATIENT:	SOCIAL SECURITY NUMBER: