**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#:\_\_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_**

The information is to be disclosed **FROM:** The information is 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.**

**The purpose or need for this disclosure is:**

**□** Medical care **□** Attorney **□** School **□** Insurance **□** Disability **□** Personal **□** Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The information to be disclosed from my health record (check all that apply)**

**□** Facesheet **□** Complete Medical Record **□** Psychotherapy Notes **□** Psychiatric Notes **□** Other:\_\_\_\_\_\_­­­­­­­­­­­\_\_\_­­­­\_\_\_

With provider(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_during the time period from\_\_\_\_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_\_.

**If you would like any of the following sensitive information disclosed, check the applicable box(es) below:**

🞎 Alcohol/Drug Abuse Treatment/Referral 🞎 HIV/AIDS Testing & Treatment 🞎 Sexual & Reproductive Health

🞎 Sexually Transmitted Diseases 🞎 Genetic Testing 🞎 Mental Health (Other than Psychotherapy notes)

*\*Expiration: This authorization shall become effective immediately and shall remain in effect until\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. If no date is given, the authorization shall be* ***valid for one year*** *from the date of signing.*

\**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 redisclosure by recipient(s) and unprotected by Federal or Sate 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. A copy of this signed and dated authorization shall be as effective as the original.* **This form must be notarized if it is mailed, faxed, or emailed to the clinic.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient/Guardian Name and Relation if Not Patient Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Witness (office staff) Signature Date**

**State of Arkansas County of \_\_\_\_\_\_\_\_\_\_\_\_\_** (Seal)

**On this day \_\_\_\_\_ of \_\_\_\_\_\_\_\_\_\_\_\_ 20\_\_\_\_.**

**I certify that the release of information is a true and exact copy of the original.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Notary Public Signature) My Commission Expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_