CARTI

TO BE SCANNED

❑ Benton ❑ Clinton ❑ Conway ❑ El Dorado ❑ Heber Springs ❑ Little Rock ❑ Mountain Home ❑ North Little Rock ❑ Russellville ❑ Searcy ❑ Stuttgart

Authorization to Release Protected Health Information

MRN#_____

Patient Name _____ Formerly Known As _____ Birth Date _____

Address_____City/State_____ Zip_____ Phone #_____

PURPOSE OF REQUEST ❑ Continuation of Care ❑ Personal ❑ Legal ❑ Insurance ❑ Other _____

I authorize release to_____ Phone # _____

Name/Facility _____ Fax # _____

Address_____ City/State_____ Zip _____

Date of service range (month/year): From _____ To _____

INFORMATION TO BE RELEASED

___History and Physical
___Billing Information
___Clinic/Progress Notes
___Complete (All records, notes, meds, flowsheets, etc.)
___Consultations/Evaluations
___Med Onc Treatment Records
___Pathology Reports
___Operative Reports
___Laboratory Reports
___Radiology Reports
___Media-free DICOM format image data
___Radiology Images
___Rad Onc Treatment Records
___Discharge/End of Treatment Summary
___Other: _____

_____

_____

I request this authorization to expire on _____or one (1) year from the date signed below and covers only treatment for the dates specified above.

_____ _____

Signature of Patient or Legal Representative **Date**

1. **Requests will be processed within 28 calendar days.**
2. I authorize the release of my medical record, including photographs.
3. This authorization is voluntary and the disclosure is made at my request.
4. If the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
5. Multiple requests are authorized if the purpose of the request remains the same.
6. I have a right to revoke this authorization at any time and if I revoke this authorization, I must do so in writing and present the written revocation to the department that I have authorized to release the information. Any revocation will not apply to information that has already been released in response to this authorization.
7. I need not sign this form to ensure health care treatment.

I am also aware fees, outlined below, for copy services may apply. NOTE: Fees/charges will comply with all laws and regulations applicable to the release of information. Standard copying fees are as follows:

.50 cents for each page from 1-25 **.25 cents for each additional page**

Additionally, an initial set of radiological CD-ROM can be provided at no cost to a patient for physician or facility referral. **However, a fee of $7.00 per CD-ROM will be charged for additional copies.**

____ Paper copies ____CD-ROM Method of Delivery: ✔ Pick-up at facility ____ Mail to address listed above

____Mail to alt address/facility: _____

For HIM Office Use Only

ID: ❑ Driver's License_____ ❑ State ID_____ ❑ Military ID_____

If signed by legal representative, indicate documentation: ❑ Death Certificate ❑ Power of Attorney ❑ Living Will

Processed by:_____ Date _____ Mailed/Faxed/Given by_____