ARKANSAS
SURGICAL HOSPITAL
PHYSICIAN OWNED

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient:	Last 4 Digits of Social Security Number:	Date of Birth:

1. I authorize the use or disclosure of my protected health information as described below.
2. The individual or organization will be charged $ _____ ☐ No Charge
3. Arkansas Surgical Hospital is authorized to make disclosures to: (Please list the complete name, address, phone and/or fax of recipient below.)

   Name: _____

   Address: _____

   City, State, Zip: _____

   Telephone: _____ Fax: _____
4. I request the record be provided in the following format: *(I understand if I request the record to be provided by unsecure email that I undertake the potential risk that the information may be obtained by someone else, the information can be opened and read by someone else, and any unencrypted information does not provide any assurances of privacy or security.)*

   ☐ Paper ☐ Encrypted CD ☐ Unsecure Email ☐ Other: _____
5. Date(s) of Service: _____ to _____.

   The extent or nature of information to be released:

   ☐ Facesheet ☐ Consultations ☐ X-Ray Reports ☐ Nurses Notes
   ☐ Emergency Room Record ☐ Progress Notes ☐ Operative Note ☐ Entire Chart
   ☐ Discharge Summary ☐ Lab Work ☐ Pathology Report ☐ Outpatient Record
   ☐ History & Physical ☐ EKG ☐ Physicians Orders
   ☐ Other - Specify: _____
6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Services. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire ninety (90) days from the date of signing below.

   I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in Section CFR 164.524 of the Health Insurance Portability and Accountability Act. I understand that if the person or entity authorized to receive the information is not a healthcare provider or health plan the released information may no longer be protected by federal privacy regulations. If I have questions about disclosure of my health information, I can contact the Health Information Management Services.

_____ _____ _____
Signature of Patient or Legal Representative Relationship to Patient Date / Time

FOR OFFICE USE ONLY

Medical Record Number: _____ **Patient Number:** _____ **Date:** _____

☐ **Faxed** ☐ **Mailed** ☐ **Pick-Up** **Completed by:** _____

Please fax completed form to (501) 748-8068 or mail to Arkansas Surgical Hospital, Attn: Medical Records, 5201 Northshore Drive, North Little Rock, AR 72118