RETURN TO: Arkansas Children's Hospital, Medical Records 800 Marshall St., Little Rock, AR. 72202

AUTHORIZATION TO RELEASE HEALTH INFORMATION

ALL ELEMENTS ARE REQUIRED PRIOR TO INFORMATION BEING RELEASED

I authorize the use/disclosure of my health information as described below:

1. Who is authorized to use/disclose the information: ACH

2. Who is authorized to receive the information (Name and address): ______________________

____

3. **The specific information to be requested or released:**

   List dates of service:______________________

_____ Discharge Summary
_____ Social History
_____ Psychological Evaluations
_____ Operative Report
_____ Psychiatric Evaluation
_____ Education Information
_____ Clinic Report
_____ X-Ray & Lab
_____ ER Report
_____ Medical Abstract
_____ Substance Abuse Treatment & Progress

4. **This information is needed for:**

_____ Continuity of Care
_____ Disability
_____ Legal Reasons
_____ Insurance
_____ School

5. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

6. I understand that Arkansas Children's Hospital will be paid for the costs of copying the information to be released.

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used/disclosed under this authorization.

8. I understand that I may revoke this authorization in writing at any time by delivering a copy of my revocation to Arkansas Children's Hospital except to the extent that action has been taken in reliance on this authorization. This authorization expires ______________________

______________________ Signature of Patient or Representative

______________________ Date

______________________ Patient's Name

______________________ Date of Birth

______________________ Name of Personal Representative (if applicable)

______________________ Relationship to Patient