Arkansas Children's
Health Information Management
1 Children's Way Slot 109
Little Rock, Arkansas 72202
Release of Information
Phone: 501−364−1268
Fax: 501−364−3968

Arkansas Children's
Health Information Management
2601 Gene George Blvd.
Springdale, AR 72762
Phone: 479-725-6533
www.archildrens.org

For Official Use Only: MR#: _____ **Acct #:** _____

AUTHORIZATION TO RELEASE HEALTH INFORMATION

ALL ELEMENTS ARE REQUIRED PRIOR TO INFORMATION BEING RELEASED

Patient Name: _____ **Date of Birth:** _____

1. Who is authorized to disclose the information? **Arkansas Children's**
2. Who is authorized to receive the information? **Name:** _____

   Complete Address:_____

   City:_____ State:_____ Zip Code:_____
3. I understand that I will be charged for the costs of copying the information to be released.
4. The specific information to be requested or released is:

   List the dates of service: _____

   ❑ Clinic Report
   ❑ Discharge Summary
   ❑ ER Report
   ❑ Lab
   ❑ Medical Abstract
   ❑ Operative Report
   ❑ Physical
   ❑ Shot Record
   ❑ X−Ray Report
   ❑ Other: _____
   ❑ Radiology Films
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 the Arkansas Children's Hospital will be paid for the cost of copying the information to 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: 1 year from date signed**
9. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental services and/or treatment for alcohol and drug abuse.

PLEASE INCLUDE A COPY OF A PHOTO ID

_____ _____
Signature of Patient or Representative Date

_____ _____
Phone Number Relationship to Patient

Witness:_____Phone Number:_____Date:_____