Advantage Primary Care
507 W. Monroe Avenue, Suite A
Lowell, AR 72745
Phone 479-463-8150
Fax 479-463-8151

WashingtonRegional

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Please fax the completed form to the WRMS Clinic.

Patient Name:_____

Birth Date:_____ Last 4 digits of your SSN:_____ Phone:_____ Home/Cell/Work

Street Address:_____ City:_____ State:_____ Zip:_____

I hereby authorize WRMS **to release information to:**

_____
Name of Facility or Person

_____
Address

_____
City, State, Zip Code

_____
Telephone Number (include area code)

I request that the released information be provided the following way:

- By Mail to:
  _____
  _____
- By Fax to: _____
- By Secure Email to:
  _____

Expiration Date:

This Authorization shall automatically expire within 120 days from date of signature below; or

- ☐ Upon occurrence of the following event:
  _____

Purpose of the Requested Use or Disclosure:

The purpose for the requested use or disclosure is:

_____

Dates of Service:

__ All dates of service
__ Date of Service From _____ To _____

Please Check the Types of Records to Be Released:

__Complete Medical Record	___Consultation	___Radiology Reports
__Discharge Summary	___Pathology Report	___Laboratory Tests
__Operative report	___EKG	___X-rays
__History and Physical	___ER Record	___Billing
__Other, Please Specify _____		

I understand that the information authorized for release may include information related to treatment of mental health conditions, alcohol or substance abuse, HIV or AIDS, sexually transmitted diseases or communicable diseases.

I do _____ / I do not _____ authorize the release of this specific information.

If you do not authorize the release of the specific information listed above, please indicate which conditions, procedures, providers and/or dates of service you wish to exclude from your authorization:

__ Mental Health Conditions
__ HIV or AIDS
__ Communicable Diseases
__ Alcohol or Substance Abuse
__ Sexually Transmitted Diseases
__ Specific procedure, provider or date of service

_____

I understand that I may inspect or request copies of any information disclosed pursuant to this authorization. I understand that I may revoke this authorization by notifying, in writing, the Washington Regional Privacy Officer in accordance with the directions set forth in the Washington Regional Notice of Privacy Practices. I acknowledge and understand that once I sign this authorization (i) Washington Regional can rely on it until I revoke it or until it expires and (ii) any information previously disclosed by Washington Regional in reliance on this authorization will not be subject to any subsequent revocation request I might make.

I understand that if I authorize the release of my health information to a recipient who is not legally required to keep it confidential, the information may be further disclosed and may no longer be protected by federal or state privacy laws.

I understand that I may refuse to sign this authorization and that Washington Regional may not condition my treatment or payment as a result of my refusal.

I agree to pay any and all fees allowable by law that are incurred by Washington Regional in complying with this authorization.

_____ _____
Signature of Patient Date

If you are acting as a legally authorized representative of the Patient, please complete the section below.

_____ _____
Printed Name of Representative Relationship to Patient
(parent, legal guardian, etc.)

_____ _____
Signature of Representative Date