HerHealth
Washington Regional
3215 N North Hills Blvd Ste B
Fayetteville, AR 72703
Phone: (479) 463-5500
Fax: (479) 463-5542

Chart # _____

AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL INFORMATION

Patient Name:_____

Birth Date:_____ Social Sec. No:_____ Phone:_____ Phone:_____
Home Work

Street Address:_____City:_____State:_____Zip:_____

I hereby authorize WRMS **to <u>release information</u> to:**	I hereby authorize WRMS **to <u>obtain information</u> from:**
_____ Name of Facility or Person	_____ Name of Facility or Person
_____ Address	_____ Address
_____ City, State, Zip Code	_____ City, State, Zip Code
_____ Telephone Number (include area code)	_____ Telephone Number (include area code)

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:

_____
[Indicate specific reasons for which medical information is sought]

Please Check the Types of Records to Be Released:

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

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 and acknowledge that to the extent the persons or entities identified herein as being authorized to receive my medical information are *not* healthcare providers or health plans covered by federal health privacy laws, they may re-disclose that information and those laws would no longer protect that disclosed medical information.

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.

Authorization to Release or Obtain Information

The information authorized for release may include records which indicate the presence of a communicable or venereal disease including, but not limited to, hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome ("AIDS"), as well as mental health information, and/or records concerning treatment for alcohol and/or drug abuse.

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 or Legal Representative Date

_____ _____
Relationship to Patient/Description of Legal Authority I.D. Type

_____ _____
Witness Date

A copy of this authorization must accompany released information.

Request Processed by: _____ Date:_____