

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Please fax the completed form to Washington Regional Medical Records at 479.463.1239

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