CONWAY REGIONAL HEALTH SYSTEM

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTHCARE INFORMATION

2302 College Ave
ATTN: MEDICAL RECORDS
Conway, AR. 72034
Office: 501-450-2130
Fax: 501-450-2103

All portions of this form must be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

Patient's Name | Date of Birth | Medical Record Number

Address | City | State | Zip | Telephone Number | Email Address

I authorize the use and disclosure of health information about me as described below:

Facility Authorized to Release my Health Information

Agency or Individual(s) Authorized to Receive my Health Information

Address | City | State | Zip | Telephone Number

Health information that may be used / disclosed is limited to the following:

☐ Progress Notes ☐ Emergency Room Record
☐ Discharge Summary ☐ History & Physical ☐ Consultation(s) ☐ Lab ☐ Pathology Report
☐ Operative Note(s) ☐ Imaging / Radiology ☐ Radiology ☐ Entire Record
☐ Other (specialty)_____

Health information that may be used / disclosed is limited to the following periods of healthcare:

From (date):_____ To (date):_____ Account Number:_____

From (date):_____ To (date:_____ Account Number: _____

Health information to be released to the *above* named agency/individual is to be used /disclosed for the following purpose(s):

☐ Treatment/Consultation ☐ At Request of Patient ☐ Research ☐ Marketing ☐ Billing or Claims Payment
☐ At Request of Employer ☐ Other

"Health Information" identifies you (the patient) by name and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, X-Ray films, slides, tracings. strips, etc.

I hereby discharge the releasing facility, it's agents, and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

☐ Yes ☐ No *If applicable* I agree to the release of my medical or billing records containing sensilive information listed above.

Protected Health Information used or disclosed pursuant to this authorization mpy be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

This authorization will automatically expire 180 days after the date of signature below (except as indicated below), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment. enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the HIPAA prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

Copy to the individual: If a covered entity seeks an authorization from an individual for a use or disclosure of protected health information, the covered entity must provide the individual with a copy of the signed authorization.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with (HIPAA) privacy regulations.

Patient's or Authorized Personal Representative's Signature | Date | Time

Relationship to Patient/Authority to Act on Patient's Behalf | Interpreter, If Used

Patient's or Authorized Personal Representative's Signature | Date | Time | Expiration Date or Event

*for Medical Records Use Only

☐ *Signature validated against driver's license or signature in Medical Record. There may be a charge for copying Medical Records.*

☐ Electronic copy requested.