REGIONAL FAMILY MEDICINE

630 Burnett Drive
Mountain Home, AR 72653
Phone: 870-425-6971 Fax: 870-508-8900

250 Drillers Road
Mountain Home, AR 72653
Phone: 870-492-5995 Fax: 870-508-8900

FAX TO: 870-508-8900

AUTHORIZATION TO OBTAIN/RELEASE PROTECTED HEALTH INFORMATION

WE WILL NOT PROCESS THIS REQUEST UNTIL WE ARE GIVEN THE *COMPLETE* NAME, ADDRESS, OR FAX NUMBER

Receive Information **from**
Name of Facility: ______________________________
Address: ______________________________________
____
Phone # ______________________________________
Fax # ____

Release Information **to**
Name of Facility: ___________________________
Address: ___________________________________
____
Phone # ___________________________________
Fax # _____________________________________

PATIENT INFORMATION:

Printed Name: ____
(Please Print Clearly to Avoid Mistakes)
Address:____

Date of Birth: _________________________ S.S. # __________________________________

Phone Number: ____

INFORMATION TO BE RELEASED COVERING THE PERIODS OF HEALTHCARE:

From (date) _________________________ To (date) ____________________________

Please check type of information to be released:

____ Entire Medical Records ____ Lab Test/Results ____ X-ray Reports ___ HIV, Drug & Alcohol

PURPOSE OF REQUEST:

____ Further Medical Records ____ Moving ____ At the Request of Patient ____ Specialist

Other (Specify) ____

I understand that this information will be given only to those identified on this form and that there is a date after which no further disclosure may be made without further authorization from me. I also understand that this authorization may allow the recipient of my health information to pass it on to others, so it may no longer be protected under federal law.
I also understand that I have the right to revoke this authorization at any time through my written notice otherwise it will expire one year from the date signed.

This information will be used for new/continuing medical care and/or financial/billing

Signature: ____ ( ) Client ( ) Parent ( ) Guardian

Printed name of Signature: ______________________________ Date: _________________ Witness Initials ________________