**East Arkansas Children’s Clinic**

**901 Holiday Drive**

**Forrest City, Ar. 72335**

 **Ph: (870) 633-0880 Fax: (501)422-0821**

**Authorization to Release Healthcare Information**

**Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request and authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

to release healthcare information on the above named patient to:

 Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Specific information to be accessed or released:

 \_\_\_ Complete Medical Record, including records of other providers on file, if any.

 \_\_\_ Information limited to the following dates of treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_ Other

 *I understand that* ***if*** *the records requested contain information on sexually transmitted disease, HIV, AIDS or related*

 *conditions, genetic testing, alcohol abuse, drug abuse, or psychiatric or psychological conditions (except psychotherapy*

 *notes), that this Authorization includes that information.*

2. The purpose of this disclosure is \_\_\_Continuity of Care \_\_\_Insurance \_\_\_Legal Reasons \_\_\_Personal

 Records \_\_\_At the request of the patient \_\_\_Other

3. This Authorization (check one):

 \_\_\_ will expire when the following event or date occurs: \_\_\_\_6 months from date of signature\_\_ **OR**

 \_\_\_ will not expire unless it is revoked in writing.

 I understand I have the right at any time to revoke this Authorization in writing except to the extent

 that [my provider already has acted in reliance on it. I understand my written revocation must be

 submitted to the Privacy Officer at: East Arkansas Children’s Clinic. A photocopy of this authorization is as valid as

 the original.

4. I realize that when the above information is disclosed, it may be re-disclosed by the recipient, and

 there is no guarantee that it will continue to be protected by the federal HIPAA Privacy Rule.

5. I understand that my provider will not condition treatment, payment for healthcare services, enrollment

 or eligibility for healthcare benefits on signing this Authorization, unless allowed by law.

6. East Arkansas Children’s Clinic, its employees and physicians are released from legal responsibility or liability for the

 release of the above information to the extent indicated and authorized herein.

7. I authorize East Arkansas Children’s Clinic to use or disclose my protected health information for

 marketing purposes. I understand that the marketing activities will involve payment to (EACC)

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 Signature of Patient or Legal Guardian Date Signed

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 If signed by Legal Guardian, Relationship to Patient Signature of Witness