3215 N. North Hills Blvd.
Fayetteville, Arkansas 72703

AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL INFORMATION

Patient Name_____

Birthdate:_____ Social Sec. No:_____ Home Phone:_____ Work Phone:_____

Address:_____ City:_____ State:_____ Zip:_____

I hereby authorize WRMC to release information to:	I hereby authorize WRMC to release information 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)

Purpose of the Requested Use or Disclosure(indicate specific reasons):_____

Please Check the Types of Records to Be Released: (Date of Service)_____

__**Complete Medical Record**	___Consultation	___Radiology **Reports** (hardcopy)	___Billing
__Discharge Summary	___Pathology Report	___Radiology **Imaging/Images**	___Other, please specify_____
__Operative report	___EKG	___Laboratory Tests/results	
__History and Physical	___ER Record	___Photo's	

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 for the in the Washington Regional Notice of Privacy Practices. I acknowledge and understand that once I sign this authorization, Washington Regional can rely on it until this authorization is revoked or expired and any information previously disclosed will not be subject to any subsequent revocation 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 WRMC may not condition to my treatment or payment as a result of my refusal.

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.

This Authorization shall automatically expire within one (1) year from date of signature, or upon occurrence of the following event: _____
___Initial if it is your desire that this authorization extend to records of your future treatment (after the date of signature) as long as such treatment occurs while this authorization is in effect.

_____	_____	_____	_____
Signature of Patient or Legal Representative	Date	Witness	Date

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

CF 011 Revised 050108

A copy of this authorization must accompany released information.
Request Processed by: _____ Date_____