Beebe Medical Center

Authorization for Release or Disclosure of Health Information

I hereby authorize Beebe Medical Center or Beebe facility to release the following information from the health records of: ___________________________________ (Please print patient's name)

Social Security #: _____ - ____ - ______ Date of Birth: ___/___ /___ Phone #: ( ) _____ - ________

Address: _____________________________________ / ___________________ / ______ / __________
(Street / Apt. Address) (City) (State) (Zip Code)

I expressly consent to the release of the record(s)/report(s) checked off below to:

____ ⇦ Here is the full name and address of the person, organization, or group who are to receive my records.
____
OR
____ ☐ Please release the records to me.

Type(s) of records:
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Operative Report(s)
- ☐ Physician's Office Records
- ☐ Emergency Room Report(s)
- ☐ Photographs, Digital Images
- ☐ Other:____
- ☐ Complete Medical Record
- ☐ Consultation Reports
- ☐ Pathology Report(s)
- ☐ Radiology Report(s)
- ☐ Lab Report(s)
- ☐ EKG Reports

Detailed Description: (for example, "X-Ray of left hand" or "MRI of head")____

____

The information that I am requesting regarding the care or services rendered checked off above was generated on these dates: ____.

When I or the above patient was an: ☐Inpatient ☐Outpatient ☐Emergency Dept. Patient ☐Resident ☐Client

The information is for the purpose of: ____.
If no purpose is stated, then the purpose of the disclosure will be "at my request."

Medical Center facility personnel will not condition treatment or payment on my signing this authorization.

I understand that, if applicable, this information shall include: AIDS or HIV results; mental illness or psychiatric care reports; and records of treatment for alcohol and/or drug abuse. Such records will be disclosed unless you specify information that you wish excluded. Exclusions:___________________________.

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Any requests for revocation must be in writing and sent to the Medical Records Department of Beebe Medical Center or any of its affiliates, if applicable. This authorization will expire in ninety (90) days.

I further understand that the information that is used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient listed above and would therefore no longer be protected under the terms of the federal HIPAA Privacy Rule. However, drug and alcohol treatment records are protected by Federal Regulation (42 CFR Part 2), which specifically prohibits re-disclosure of this information.

I certify that I have read the provisions set forth in this authorization. I understand and agree to its terms.

✘ _____________________________ ___ /___ /___ ________________________ ___ /___ /___
(Signature of Patient) (Date) (Signature of Witness) (Date)

If you are signing as a Personal Representative for the above patient, *you will be asked to provide proof of your identity and of your authority to sign for the patient. Please fill out & sign below:*

Your name (please print):________________________ Your relationship to the patient:______________

Your signature: ___________________________________ Date: ___ / ___ / ___

For office use only:

Information released by: ____________________________ Date: ___ / ___ / ___

Department: ☐ Medical Records Dept. ☐ Cardiovascular ☐ ED ☐ Rehab ☐ Lab ☐ Diagnostic Imaging ☐ Wound Care ☐ Surgical Services ☐ Oncology ☐ Other: ________________

Facility: ☐Medical Center ☐LCC ☐BHH ☐LPD ☐LID ☐BHC ☐Other _________________________