(Place MR Label Here)
MR#:
Patient's Name:
Patient's Address:

UAMS MEDICAL CENTER
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

Permission to Share Information with Family or Friends Involved in Your Care

We respect the privacy of your health information. If you wish to grant permission for us to share your medical or billing information with a family member or friend involved in your care, who is not otherwise authorized by law to act on your behalf, please specify below. You are not required to grant this permission and may revoke this permission at any time by contacting the UAMS HIPAA Office at 501-603-1379.

I give my permission to UAMS to share the health information of

_____ _____
Print patient name Print Date of birth

with the following person or persons:

Name	Relationship	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient or Legal Representative Signature: _____

Date: _____ Time: _____

Print Name: _____

If Legal Representative, authority of Legal Representative: _____

(such as parent of a minor, guardian, attorney-in-fact appointed with power of attorney or healthcare proxy)