

(Place MR Label Here)

MR#:

Patient's Name:

Patient's Address:



Authorization for Release of Information TO UAMS

1. I, _____, hereby authorize:

Name/Facility _____

Complete Address _____
Street Address City State Zip

Phone _____ Fax _____

2. To release to: UAMS Medical Center

Dr./Clinic _____

4301 West Markham, Mail # _____

Little Rock, AR 72205

Phone (501) _____

Fax (501) _____

3. Information of:

Patient name _____ Medical Record # (if known) _____

Birthdate and / or Soc Sec No. _____ Phone _____

4. Information is to be limited to the following Dates of Treatment (if applicable): _____

5. Information requested to be released: _____ Abstract _____ Operative Report _____ ER Record
_____ History & Physical _____ Clinic Record _____ Discharge Summary _____ Admission Record
_____ Physicians' Progress Notes _____ Nurses' Progress Notes _____ Other _____

6. Purpose of release is at the request of the patient or: _____ Insurance or Other Payment
_____ Medical Care _____ Other (explain): _____

7. This authorization will expire 90 days from the date on which it was signed unless I specify a different time period. Expiration Date or Event: _____. I understand that I may revoke this authorization at any time by giving written notice. A revocation of this authorization will not apply to records already released in reliance upon the authorization. A photocopy of this signed authorization shall constitute a valid authorization.

8. I understand that once the above information is disclosed, it may be re-disclosed by the designated recipient and the information may no longer be protected by federal privacy laws and regulations.

9. Treatment, payment, enrollment or eligibility for benefits will not be conditioned on your signing this authorization.

Signature of Patient
or Legal Representative _____ Date/Time _____

If Legal Representative, authority of Legal Representative _____
(such as parent of a minor, court-appointed guardian, administrator of estate of deceased, attorney-in-fact appointed with power of attorney, or healthcare proxy)



Provide a copy to Patient/Legal Representative