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

UAMS
Medical Center

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