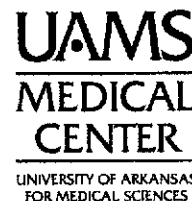


(Place MR Label Here)

MR#:

Patient's Name:

Patient's Address:



**Authorization for Release of Information from UAMS
Chemical Dependency Outpatient Program**

Send Information To:

I, _____, hereby authorize UAMS to release to:

Name: _____ Phone: _____ Fax: _____

Complete Address: _____
Street Address City State Zip

Patient Information:

Patient name: _____ Medical Record # (if known): _____

Birthdate and / or Soc Sec No: _____ Patient phone: _____

Information Requested (check):

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

Information requested to be accessed or released:

- Patient medical record of UAMS Substance Abuse Treatment Clinic; or
- Portions of medical record as follows: _____

(If only portions of record request, specifically describe portions of record to be released)

Purpose:

(describe purpose of release of information as specifically as possible)

I understand that my alcohol and drug treatment records are protected by federal law. Confidentiality and Drug Abuse Patient Records, 42 Code of Federal Regulations Part 2, and Health Insurance Portability and Accountability Act (HIPAA) 45 CFR. parts 160 & 164, and cannot be disclosed without my written permission, unless otherwise allowed by law.

I understand that UAMS Substance Abuse Treatment Clinic may not condition my treatment or eligibility for benefits on whether I sign an authorization to release my medical information.

I understand that I may, at any time, **revoke this authorization** by notifying UAMS Substance Abuse Treatment Clinic in writing, except to the extent that records / information have been released in reliance upon this authorization. If not previously revoked, **this authorization expires automatically 30 days after patient is discharged from UAMS-SATC** or upon the following date: _____.

I hereby authorize the UAMS Substance Abuse Treatment Clinic to release my alcohol or drug treatment records as stated above.

Signature of Patient or Legal Representative _____ Date/Time _____

Signature of Witness: _____ Date _____

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

*42 CFR Part 2 Statement is to be sent with each release of information: [] yes [] no, explain:



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Psych Consents

Provide a copy to Patient/Legal Representative

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.