(Place MR Label Here)
MR#:
Patient's Name:
Patient's Date of Birth:

UAMS Medical Center

Patient Request for Release of Information from UAMS

1. I, _____, hereby request information of:
   (Patient or the Patient's Legal Representative)

   Patient Name _____ Medical Record No. (if known) _____

   Date of Birth and/or Social Security No. _____ Patient Phone _____

2. I hereby direct UAMS to release the information requested to:

   Name _____ Phone _____

   Complete Address _____
   Street Address City State Zip

   E-mail _____

3. Please select both the format (paper or electronic) you want UAMS to provide the information and the method of delivery (for example, e-mail, mail or you will pick up at UAMS).

   Format: ☐ Paper Copy ☐ Electronic Copy

   Method of Delivery:

   ☐ I will pick up at UAMS

   ☐ E-mail to address indicated above

   ☐ Mail to address listed above

   ☐ Other (please specify; for example, unencrypted flash drive, CD)

   _____

Warning and Assumption of Risks: UAMS does not guarantee information sent via email is secure and encrypted. There are security risks associated with emailing information in an unsecure and unencrypted manner, including, but not limited to, an unauthorized person or entity accessing or using the information. By requesting that UAMS send the information via email, I acknowledge I have been warned of and accept such risks.

UAMS does not guarantee information stored or maintained on an unencrypted flash drive/thumb drive is secure or protected. There are security risks associated with maintaining information on an unencrypted flash drive/thumb drive, including, but not limited to, an unauthorized person or entity accessing or using the information. By requesting that UAMS deliver it on an unencrypted flash drive/thumb drive, I acknowledge I have been warned of and accept such risks.

(Place MR Label Here)
MR#:
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Patient Request for Release of Information from UAMS *(continued)*

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

   _____

5. Information requested to be accessed or released:

   ☐Abstract ☐ Operative Report ☐ER Record ☐History & Physical

   ☐Discharge Summary ☐ Clinic Record ☐Physicians' Progress Notes

   ☐Nurses' Progress Notes

   ☐Other _____

   ☐Records of Other Providers on File with UAMS (if any) *(We must impose our standard fees as stated below. UAMS does not represent that these records are the complete records of the other providers. If you want a complete copy of the records created by the other providers for this patient, you may wish to contact each provider.)*

   I understand that if the records requested to be released include photographs, videos or other images, and/or information relating to **sexually transmitted disease, AIDS or HIV, alcohol or drug abuse, or mental health information,** including records from UAMS Psychiatric Research Institute, this information may be released pursuant to this request.

6. _____ Billing Records. For billing records, please contact UAMS Billing Office Customer Service at (501) 614-2160 or 1-800-422-3963.

7. I acknowledge I have received a copy of the attached fee schedule and agree to pay the copying cost, including other expenses allowed by law, such as the cost of any supplies, labor of copying, postage, or other expenses incurred by UAMS to provide the copies requested.

Signature of Patient or Legal Representative _____ 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 health care proxy)

UAMS Release of Information
4301 W Markham Street, Slot 524
Little Rock, AR 72205
Phone: 501-603-1520
Fax: 501-252-6013
Email: recordrequests@uams.edu