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

UAMS Medical Center

Authorization for Release of Information FROM UAMS

1. I, _____, hereby authorize UAMS to release to:

   Name _____ Phone _____ Fax _____

   Complete Address _____
   Street Address *City* *State* *Zip*

2. Information of:
   Patient Name _____ Medical Record # (if known) _____

   Birthdate and / or Soc Sec No. _____ Patient Phone _____

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

4. Information requested to be accessed or released: ____ Abstract ____ Operative Report ____ ER Record

   ____ History & Physical ____ Clinic Record ____ Discharge Summary ____ Admission Record

   ____ Physicians' Progress Notes ____ Nurses' Progress Notes ____ Other_____

   ____ Records of Other Providers On File With UAMS (if any). *(We must impose our standard copying 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 information relating to **sexually transmitted disease, AIDS or HIV, alcohol or drug abuse, or mental health information, including records from the UAMS Psychiatric Research Institute**, this information may be released pursuant to this authorization.

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

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 to UAMS. 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. UAMS, its employees and attending physicians are released from legal responsibility or liability for the release of above information to the extent indicated and authorized herein.
9. 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.
10. I 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 expense incurred by UAMS to provide the copies requested.
11. UAMS will not condition treatment, payment, enrollment, or eligibility for benefits on your signing of this authorization.

Signature of Patient
or Legal Representative _____ Date/Time _____

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)

Provide a copy to Patient/Legal Representative

UAMS
4301 West Markham, Slot 524, Little Rock, Arkansas 72205
Fax: 501-686-8361 ● Email: records@uams.edu