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

UAMS Medical Center

Authorization for Release of Radiology Imaging from UAMS

1. I, _____, hereby authorize UAMS to release to:
   Name_____ Phone_____ Fax_____
   Complete Address_____
   Street *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 dates unknown, the most recent images will be provided). Please list date of service and exam type (example: CT, MRI, X-Ray) requested.
   Date: _____ Exam: _____
   Date: _____ Exam: _____
   Date: _____ Exam: _____
4. *In the case of requested copies of uploaded images from other providers on file with UAMS, 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 other providers for this patient, you may wish to contact each provider.*
5. I understand that if the records requested to be released include information relating to **sexually transmitted diseases, AIDS, 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.
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 to 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 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 deceased, attorney-in-fact appointed with power of attorney, healthcare proxy)

Provide a copy to Patient/Legal Representative

UAMS PACS (Imaging) Office
4301 West Markham, Slot 556
Little Rock, AR 72205
Phone: 501-603-1152 or 501-526-0369
Fax: 501-686-8823

*For **UAMS medical records other than imaging**, please contact:*
Medical Records: Phone-(501)603-1520. Fax-(501)686-8361
Billing Records: Phone-(501)614-2160 or (800)422-3963