ARKANSAS SURGICAL HOSPITAL
PHYSICIAN OWNED

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient:	Last 4 Digits of Social Security Number:	Date of Birth:

I authorize the use or disclosure of my protected health information as described below.

1. Arkansas Surgical Hospital is authorized to make disclosures to: (Please list the complete name, address, phone and/or fax of recipient below.)

   Name: _____

   Address: _____

   City, State, Zip: _____

   Telephone: _____ Fax: _____

   ☐ **Please check here if you will pick up your records from Arkansas Surgical Hospital**.

2. I request the record be provided in the following format: *(I understand if I request the record to be provided by unsecure email that I undertake the potential risk that the information may be obtained by someone else, the information can be opened and read by someone else, and any unencrypted information does not provide any assurances of privacy or security.)*

   ☐ Paper ☐ Encrypted CD ☐ Imaging CD (for Radiology imaging only)

   ☐ Encrypted Email: _____ ☐ Other: _____

3. Date(s) of Service: ☐ MOST RECENT **OR** _____ to _____
   (*It is acceptable to write "most recent" in one field or a given approximation of time, ex: 2021-2022. If you don't know a time frame, but had surgery, please use the Other- Specify field below to give as much detail for a medical record clerk to find the most appropriate file or files)*

4. The extent of information to be released:

   ☐ Complete Record **OR** ☐ Clinical Summary/Abstract *(which includes the H&P, Operative Report, Progress Notes, Discharge Summary, and any Labs And/or Radiology Reports)*

   OR

   ☐ Operative Report
   ☐ MRI Report **and/or** ☐ MRI Imaging CD
   ☐ Radiology Report **and/or** ☐ Radiology Imaging CD
   ☐ History & Physical
   ☐ Progress Note (Implant Information)

   OR

   ☐ Other - Specify: _____

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Info. Mgmt. department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire 12 months from the signature date of the patient or legal representative.

   I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I may inspect or copy the information to be used or disclosed, as provided in Section CFR 164.524 of the Health Insurance Portability and Accountability Act. I understand that if the person or entity authorized to receive the information is not a healthcare provider or health plan the released information may no longer be protected by federal privacy regulations. If I have questions about disclosure of my health information, I can contact the Health Information Management Services.

_____ _____ _____
Signature of Patient or Legal Representative | Relationship to Patient | Date / Time

Please submit a completed form by one of the following methods:
Fax: (501) 748-8068
Mail: Arkansas Surgical Hospital, Attn: Medical Records, 5201 Northshore Drive, North Little Rock, AR 72118
Email: mrecords@arksurgicalhospital.com

FOR OFFICE USE ONLY

MRN: _____ **Encounter #(s):** _____ **Date:** _____

☐ **Faxed** ☐ **Mailed** ☐ **Picked-Up** ☐ **Emailed** **Intake Employee:** _____ **Processed by HIM Clerk:** _____