UNIVERSITY OF ARKANSAS
STUDENT AFFAIRS
Pat Walker Health Center
525 N. Garland Ave. · Fayetteville, Arkansas 72701 · (479)575-4477 · (479)575-8793 (FAX) · bb025@uark.edu

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

1. I, (Patient's name): _____
   Date of Birth: _____ Social Security Number: _____
   Contact Information (Telephone # or e-mail address) _____
   Please print any previous names under which records may be found: _____

2. hereby authorize ☐ PWHC ☐(Other)_____

   Address:_____
   Street Address City State Zip
   Telephone: _____Fax Number: _____

3. to release the following information: _____
   ____ Records of other providers on file with PWHC (if any). *(We must impose our standard copying fees. PWHC 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**, this information may be released pursuant to this authorization.

4. to: Pat Walker Health Center ____
   myself ____
   Other _____

   Recipient Address:_____
   Street Address City State Zip
   Telephone: _____ Fax Number: _____

5. Purpose of access or release: _____Medical Care; _____Insurance or Other Payment;
   _____At Request of the Patient; _____Other (explain)_____.

(1/2014 HIPAA)

I understand the following: (A) the nature of the information to be released; (B) to whom the information is being released; (C) why the information is being requested/released; (D) once the above information is disclosed, it may be re-disclosed by the designated recipient and the information may no longer by protected by Federal privacy laws and regulations; and (E) repercussions which might occur due to my release of or failure to release the information specified above have been explained to me.

I also understand that I may refuse to release confidential information or revoke this authorization at any time by giving written notice to PWHC. 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.

PWHC, its employees and providers are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. PWHC will not condition treatment, payment, enrollment or eligibility for benefits on your signing of this authorization.

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 expenses incurred by PWHC to provide the copies requested.

This authorization will expire in 90 days from the date on which it was signed unless I specify a shorter time period. Expiration date or event: _____

Patient's Signature _____ Date signed:_____
Witnessed by: _____Type of identification presented: _____