UNIVERSITY OF ARKANSAS | Student Affairs
Pat Walker Health Center

Health Information Management Department
P: 479-575-4477 | F: 866-409-1980 | E: 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 ☐ Medical Services, PWHC ☐ (Other)____________________

   Address:__ ____________________
   Street Address City State Zip
   Telephone: ____________________Fax Number: ____________________

3. to release the following information: ____________________
   _____ Records of other providers on file with MS-PWHC (if any). *(We must impose our standard copying fees. MS-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.)*

____ (initials required) I understand that some records are protected by special federal confidentiality rules (42 CFR Part 2) which prohibit disclosure unless authorized by specific written consent and **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: Medical Services, 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)____________________.

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-MS. 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.

MS-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. MS-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 MS-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: ____________________