# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO ARKANSAS FAMILY CARE NETWORK, P.A. ("AFCN")

1. I, _____, authorize the below to disclose certain protected health information to
Printed Name
**Arkansas Family Care Network, P.A.:**

Name/Facility_____Phone_____Fax_____

Address_____.
Street City State Zip

2. Name of Patient whose information is to be disclosed:_____ Date of Birth:_____
Printed Name

AFCN Clinic where information is to be sent:_ Little Rock Family Practice-West _____
_ Fax 501-228-2285 _____Attn: Dr._____.

3. Specific information to be accessed or released:
___ Complete Medical Record, including records of other providers on file with AFCN, if any.
___ Information limited to the following dates of treatment:_____
___ History & Physical ___Diagnosis ___Lab Reports ___Pathology Reports ___Radiology Reports
___ X-rays, ultrasounds, and any other images, only if specifically requested by designated recipient.
___Billing Records ___Other_____

*I understand that if the records requested contain information on sexually transmitted disease, HIV, AIDS or related conditions, genetic testing, alcohol abuse, drug abuse, or psychiatric or psychological conditions (except psychotherapy notes), that this Authorization includes that information.*

4. The purpose of this disclosure is ___Continuity of Care ___Insurance ___Legal Reasons ___Personal Records
___At the request of the patient ___Other_____

5. This Authorization (check one):
___ will expire when the following event or date occurs: _____ OR
___ will not expire unless it is revoked in writing.

I understand I have the right at any time to revoke this Authorization in writing except to the extent that records have already been released in reliance on it. I understand my written revocation must be submitted to AFCN Clinic's Privacy Officer at _____. A photocopy of this Authorization is as valid as the original.

6. I realize that when the above information is disclosed, it may be re-disclosed by the recipient, and there is no guarantee that it will continue to be protected by the federal HIPAA Privacy Rule.

7. I understand that AFCN will not condition treatment, payment for healthcare services, enrollment or eligibility for healthcare benefits on signing this Authorization.

8. AFCN, its employees and physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

_____ _____
Signature of Patient or Legal Guardian Date Signed

_____
Name of Legal Guardian*, if applicable (Printed)

**If signed by Legal Guardian, please attach copy of court records establishing guardianship, or describe other legal authority to act for Patient (e.g., parent of unemancipated minor).*