

**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: _____
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, other communicable diseases, genetics, 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: AFCN Privacy Officer Jeff Erwin, 5125 Northshore Drive, North Little Rock, AR 72118; Fax: 501-224-1927. 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).*