AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

LEAVE THIS AREA BLANK

I hereby authorize_____ _____or the Arkansas Worker's Compensation Commission to disclose the following health records relating to physical, mental or emotional conditions of:

PATIENT NAME:_____
DATE OF BIRTH:_____
SOCIAL SECURITY NO.:_____

The type of information to be used or disclosed is as follows:

THE ENTIRE RECORD INCLUDING BUT NOT LIMITED TO THE FOLLOWING: Discharge Summary, Progress Notes, History and Physical Examinations, Laboratory Tests, Radiological Reports, Physician's Orders, Physician's Notes, Nurses Notes, Pathology Reports, Consultation Reports, Correspondence, Pharmaceutical Records, Medication Administration Records, Billing Records All Records of Other Providers, Emergency Room and Ambulance Records, Patient Information Sheets/Questionnaires, Other. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may include information about behavioral or mental health services and treatment for alcohol and/or drug abuse.

This information is to be disclosed to and used by the following individual or organization:

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health care provider in question. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will be for the period of
and will expire three years from date of signature.

Purpose of Form: Workers' Compensation:
I understand that once the above information is disclosed, there is potential for the designated recipient or recipients to re-disclose the information and that the information may no longer be protected by federal privacy laws and regulations. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign this authorization will not affect my ability to obtain treatment, receive payment, or eligibility for benefits.

I waive any rule or regulation of any physician, hospital, medical attendant, Social Security Administration, the Arkansas Workers' Compensation Commission, or other medical provider concerning any lapse of time between the date of this medical authorization and the date on which there is a request for information, documents, or records, so that the holder of this medical authorization shall not be precluded from obtaining the medical information, documents, or records by reason of such lapse of time.

A photocopy of this authorization shall be as effective as the original.

_____ _____
Signature of patient or legal representative Date

_____
Printed Name