Baxter Regional Medical Center
624 Hospital Drive Mountain Home AR 72653

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

(PLEASE PRINT)

Printed Name of Patient	Previous Name (if applicable)	Social Security Number
Date of Birth	Telephone Number	Date of Service	Medical Record Number

RELEASE INFORMATION TO (Please be specific):
Provider Name/Organization/Person: _____

Address: _____

Telephone #: _____ Fax #: _____

INFORMATION TO BE RELEASED FROM:
☐ Baxter Regional Medical Center and subsidiary agencies
☐ Baxter Regional Clinic (please specify clinic name(s)): _____

The type of information to be disclosed is as follows (check the appropriate boxes and include other information where indicated:

☐ Pertinent Documents ☐ Complete Record ☐ Discharge Summary ☐ Consultation ☐ EKG (s) ☐ Pap Smear
☐ X-ray(s) ☐ Operative Report ☐ Pathology Report ☐ Lab Report (s) ☐ Other _____

1. This authorization will automatically expire on (upon) 60 days or _____
(Applicable Date or Event)
2. I understand Baxter Regional Medical Center may be paid for the cost of copying the information to be disclosed.
3. I understand that the information in my medical record may include information relating to any treatment for **HIV/AIDS, alcohol and/or drug abuse, behavioral health, or psychiatric patient information.**

Purpose of Disclosure: ☐ Personal Use ☐ Continued Care ☐ Legal Purposes ☐ Insurance Purposes
☐ Other: _____

I understand my refusal to sign this authorization will not affect my ability to receive treatment.

I understand that I may revoke this authorization in writing except to the extent that Baxter Regional Medical Center has already acted upon the authorization or in the case of other exceptions as stated in the Notice of Privacy Practices. I understand that I have a right to request and receive a Notice of Privacy Practices from Baxter Regional Medical Center.

I understand that Baxter Regional Medical Center employees and my attending physician and his or her associates who participate in my care cannot be responsible for confidentiality of information disclosed after said information has been released pursuant to this authorization, and I hereby release them from liability arising from any such disclosure.

Signature of Patient or Representative	Date
Witness	Date

For Hospital Use Only:
☐ Verified Identity (ex: driver's license, check signature, etc.) ☐ Picked up (who) _____ ☐ Mailed ☐ Faxed
Comments: _____
Hospital Personnel: _____ Date: _____