Washington Regional

3215 N. Northhills Boulevard
Fayetteville, Arkansas 72703
Main Number 479.463.1000

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Please fax the completed form to WRMC Medical Records at (479) 463-1239

Patient Name:____

Birth Date:__________ Last 4 digits of your SSN:______________ Phone:____________ Home/Cell/Work

Street Address:__________________________City:___________State:_______Zip:_______

I hereby authorize WRMS **to release information to:**

Baxter Regional Cardiology Clinic at Harrison
Name of Facility or Person

1420 Hwy 62/65 North, Suite 2
Address

Harrison, AR 72601
City, State, Zip Code

(870) 741-6065
Telephone Number (include area code)

I request that the released information be provided the following way:

- By Mail to:
  ____
  ____
- By Fax to: ______________________
- By Secure Email to:
  baxterregional.crossroadsclinic@bhcawp.eclinicaldirectplus.com

Expiration Date:

This Authorization shall automatically expire within 120 days from date of signature below; or

- ❑ Upon occurrence of the following event:
  ____

Purpose of the Requested Use or Disclosure:

The purpose for the requested use or disclosure is:

____

Dates of Service:

✓ All dates of service
__ Date of Service From _______________ To __________________

Please Check the Types of Records to Be Released:

✓Complete Medical Record
__Discharge Summary
__Operative report
__History and Physical
__Other, Please Specify ________________________
___Consultation
___Pathology Report
___EKG
___ER Record
___Radiology Reports
___Laboratory Tests
___X-rays
___Billing

I understand that the information authorized for release may include information related to treatment of mental health conditions, alcohol or substance abuse, HIV or AIDS, sexually transmitted diseases or communicable diseases.

I do ________ / I do not _________ authorize the release of this specific information.

If you do not authorize the release of the specific information listed above, please indicate which conditions, procedures, providers and/or dates of service you wish to exclude from your authorization:

__ Mental Health Conditions
__ HIV or AIDS
__ Communicable Diseases
__ Alcohol or Substance Abuse
__ Sexually Transmitted Diseases
__ Specific procedure, provider or date of service

____

I understand that I may inspect or request copies of any information disclosed pursuant to this authorization. I understand that I may revoke this authorization by notifying, in writing, the Washington Regional Privacy Officer in accordance with the directions set forth in the Washington Regional Notice of Privacy Practices. I acknowledge and understand that once I sign this authorization (i) Washington Regional can rely on it until I revoke it or until it expires and (ii) any information previously disclosed by Washington Regional in reliance on this authorization will not be subject to any subsequent revocation request I might make.

I understand that if I authorize the release of my health information to a recipient who is not legally required to keep it confidential, the information may be further disclosed and may no longer be protected by federal or state privacy laws.

I understand that I may refuse to sign this authorization and that Washington Regional may not condition my treatment or payment as a result of my refusal.

I agree to pay any and all fees allowable by law that are incurred by Washington Regional in complying with this authorization.

____ ________________

Signature of Patient Date

If you are acting as a legally authorized representative of the Patient, please complete the section below.

____ ______________________________

Printed Name of Representative Relationship to Patient (parent, legal guardian, etc.)

____ ______________________________

Signature of Representative Date