



Medical Records/P.O. Box 1848/Mena, AR 71953/Phone: 888-710-8220/Fax: 866-573-0761

AUTHORIZATION TO DISCLOSE/OBTAIN HEALTH INFORMATION

First Name		Middle Name		Last Name		Date of Birth		Today's Date	
Address				City			State		ZIP Code
Phone			Social Security Number		Previous names (if applicable):				
Are you transferring out of our facility? <input type="checkbox"/> YES <input type="checkbox"/> NO		I authorize Healthy Connections to: <input type="checkbox"/> Obtain my records from <i>or</i> <input type="checkbox"/> Release my records to:			The purpose of this disclosure: <input type="checkbox"/> Medical <input type="checkbox"/> Legal <input type="checkbox"/> Disability <input type="checkbox"/> Insurance <input type="checkbox"/> At the request of patient				
Facility Name			Doctor's Name		Facility Phone			Facility Fax	
Address				City			State		ZIP Code
The type(s) of information to be used or disclosed are as follows: <input type="checkbox"/> Entire Record <input type="checkbox"/> History & Physical <input type="checkbox"/> Discharge Summary <input type="checkbox"/> ED Record <input type="checkbox"/> Consultations <input type="checkbox"/> Billing Records <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Radiology Films <input type="checkbox"/> Psychosocial Assess. <input type="checkbox"/> Psychiatric Intake & Eval. <input type="checkbox"/> Progress Reports <input type="checkbox"/> Other: _____									
If you would NOT like any of the following sensitive information, disclosed, check the applicable box(es) below: <input type="checkbox"/> Alcohol/Drug Abuse Treatment/Referral <input type="checkbox"/> Mental Health (<i>Other than Psychotherapy Notes</i>) <input type="checkbox"/> Sexually Transmitted Diseases <input type="checkbox"/> Genetic Testing <input type="checkbox"/> HIV/AIDS Testing & Treatment <input type="checkbox"/> Sexual & Reproductive Health (<i>PAP and HPV tests</i>)									

- This authorization will be valid for a period of one year from the date below. I understand that I may revoke this authorization at any time by notifying Medical Records in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.
- I understand that my treatment or continued treatment by Healthy Connections, Inc. is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it.
- I understand this authorization is inclusive of ALL the information contained in my files. This may include alcohol, drug and psychological information. And any information relating to pregnancy, sexually transmitted diseases, HIV testing, AIDS, and any AIDS-related syndromes. It may also include information concerning cancer, cancer testing, and cancer results.
- I agree that a copy or a fax of this release shall be valid as the original release and release Healthy Connections from any liability for potential breach of confidentiality due to misdirection of transmission failure to receive transmission of my records.
- The parent or legal guardian must sign this authorization if the patient is a minor (under age 18) or has a legal guardian.
- Healthy Connections, its employees and providers are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.
- I agree to pay the copying cost, including other expenses allowed by law, such as the cost of any supplies, labor of copying, postage, or other expenses incurred by Healthy Connections to provide the copies requested I understand that I may inspect or copy the information to be used or disclosed.

I, the undersigned patient or legal representative, hereby authorize the use and disclosure of health information including, if applicable, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and HIV related information.

Signature of Patient or Legal Representative **Date** **Time**

Witness **Date** **HCI Provider**

Authorized Signers Relationship to Patient: SELF PARENT LEGAL GUARDIAN CONSERVATOR EXECUTOR OF ESTATE
 POWER OF ATTORNEY Other: _____

If signed by the Legal Representative attach appropriate documentation to verify authority