AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient: I, ______________________________________ ______________________________________

Print Name of Patient | Print Address of Patient

Date of Birth: _____/______/________ **Social Security Number**: ________________________________

authorize release of my medical information by Levi Hospital specifically for dates of service from _________________ to_______________, to ____,

Month/Day/Year | Month/Day Year | Print Name of Person/Institution Receiving Information

Other Requesting Party: I, ______________________________________, having provided adequate proof

Name of Requesting Party

of legal representation as defined by Arkansas Law for _____________________________, consent

Name of Patient

to the release of medical information for service dates from ______________ to ______________

Month/Day/Year | Month/Day/Year

releasing to ______________________________________ _________________________________.

Print Person/Institution Receiving Information | Print Address

(A copy of the proof of legal representation must be attached to this request.)

Purpose for disclosure: ____.

Portion of medical information to be released (Check all that applies):

_____ Patient Identifying Data _____ Clinical Observations _____ Diagnostic/Therapeutic Orders

_____ Medical History/Physical Examination _____ Reports of Procedures/Tests

_____ Others: ____

I understand that information released may contain references to HIV and/or AIDS, tests of therapeutic orders as a result of a positive HIV/AIDS test.

This authorization is subject to revocation at any time. Without prior revocation, this authorization will automatically expire ninety (90) days from authorization date. The party signing this authorization has a right to receive a copy of it. The original authorization and a copy of provided written legal representation will be maintained as part of the permanent medical record.

REQUIREMENT: Make photocopy of Patient's or Requesting Party's Driver's License within square.

Get ORIGINAL signature on COPY of Authorization WITH Photo ID.

__________________________________ ______________________________ ________________

Signature of Patient/Legal Representative | Printed Name of Patient/Representative | Date

Home Telephone #: __________________________ Work Telephone #: ______________________

____ Date: ______________

Printed Name of Levi Hospital Representative Taking Information

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Signature of Levi Hospital Representative Taking Information

Mail completed form and ID to: Levi Hospital, Attn: Medical Records, 300 Prospect Ave. Hot Springs, AR 71901

Or Fax to Medical Records Department at 501-622-3359