Autumn Road Family Practice, P.A.
Medical Record Release Form

1. I, (patient name) _____ **(PLEASE PRINT)** hereby authorize disclosure of protected health information about me as described below. Include other names under which we may find your record _____**(PLEASE PRINT)**.

2. Release my records (Circle From/To as appropriate):

MUST CIRCLE FROM or TO — **FROM** / **TO**	Autumn Road Family Practice, P.A. 904 Autumn Road, Suite 200 Little Rock, AR 72211 Phone: 501-227-6363 Fax: 501-227-8629
MUST CIRCLE FROM or TO — **FROM** / **TO**	Facility Name/Physician/Self: _____ Address: **(Must have full address including P.O. Box, etc.)** _____ _____

3. The specific information (***Dates and Materials***) that should be disclosed:

_____

4. **Purpose of disclosure**: ___ Insurance ___Legal___Continuing care___Personal___Disability___Wrker's Comp___Other
5. 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 also include information about behavioral or mental health services, psychiatric or psychological conditions, treatment for alcohol and/or drug abuse, drug related conditions and alcoholism.
6. I understand I will be charged for PERSONAL copies of my medical record in accordance with Arkansas Code 16-46-106. To cover the cost, state law provides for a charge of $15.00 for processing, $.50 for the first 25 pages then $.25 for all pages thereafter; and, any mailing cost/supplies involved.
7. I understand that requests for full medical record copies are processed through a 3rd party company.
8. I understand the information used or disclosed may be subject to re-disclosure by the recipient and would no longer be protected by federal privacy regulations.
9. I may revoke this authorization by notifying Autumn Road Family Practice in writing. I understand that any action or information already taken on this authorization cannot be reversed, and my revocation will not affect these actions.
10. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization; I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CER 164.524.
11. This authorization expires one (1) year after the date of signature.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING. MISSING OR INCOMPLETE ADDRESSES, ETC., WILL CAUSE A DELAY.

_____ **PRINTED NAME(S)**

_____	_____	_____
Signature of Individual	Date of Birth or SS #	Today's Date (M/D/Yr) (EXPIRES IN ONE YEAR)

■ Or, if applicable:

_____	_____	_____
Signature of Guardian or Personal Representative of Patient's Estate	Describe Authority to Act for Individual	Today's Date (M/D/Yr) (EXPIRES IN ONE YEAR)