(Place MR Label Here)
MR#:
Patient's Name:
Patient's Address:

UAMS MEDICAL CENTER
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

Authorization for Release of Information from UAMS Chemical Dependency Outpatient Program

Send Information To:

I, _____, hereby authorize UAMS to release to:

Name: _____ Phone: _____ Fax: _____

Complete Address: _____
Street Address *City* *State* *Zip*

Patient Information:

Patient name: _____ Medical Record # (if known): _____

Birthdate and / or Soc Sec No: _____ Patient phone: _____

Information Requested (check):

Information is to be limited to the following **Dates of Treatment** (if applicable): _____

Information requested to be accessed or released:

____ Patient medical record of UAMS Substance Abuse Treatment Clinic; or
____ Portions of medical record as follows: _____

_____
(If only portions of record requestion, specifically describe portions of record to be released)

Purpose:

_____
(describe purpose of release of information as specifically as possible)

I understand that my alcohol and drug treatment records are protected by federal law. Confidentiality and Drug Abuse Patient Records, 42 Code of Federal Regulations Part 2, and Health Insurance Portability and Accountability Act (HIPAA)45 CFR. parts 160 & 164, and cannot be disclosed without my written permission, unless otherwise allowed by law.

I understand that UAMS Substance Abuse Treatment Clinic may not condition my treatment or eligibility for benefits on whether I sign an authorization to release my medical information.

I understand that I may, at any time, **revoke this authorization** by notifying UAMS Substance Abuse Treatment Clinic in writing, except to the extent that records / information have been released in reliance upon this authorization. If not previously revoked, **this authorization expires automatically 30 days after patient is discharged from UAMS-SATC** or upon the following date: _____.

I hereby authorize the UAMS Substance Abuse Treatment Clinic to release my alcohol or drug treatment records as stated above.

Signature of Patient
or Legal Representative _____ Date/Time _____

Signature of Witness: _____ Date _____

If Legal Representative, authority of Legal Representative _____
(such as parent of minor, court-appointed guardian, administrator of estate of deceased, attorney-in-fact appointed with power of attorney, or healthcare proxy)

***42 CFR Part 2 Statement is to be sent with each release of information: [ ] yes [ ] no, explain:**

_____

Provide a copy to Patient/Legal Representative