

(Place MR Label Here)  
MR#:  
Patient's Name:  
Patient's Date of Birth:



**Authorization for Release of Information TO UAMS**

1. I, \_\_\_\_\_ hereby authorize:  
Name/Facility \_\_\_\_\_  
Complete Address: \_\_\_\_\_  
*Street Address* *City* *State* *Zip*  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_
2. To release to: **UAMS Medical Center**  
**Dr./Clinic -** \_\_\_\_\_  
**4301 West Markham, #** \_\_\_\_\_  
**Little Rock, AR 72205**  
**Phone (501)** \_\_\_\_\_  
**Fax (501)** \_\_\_\_\_
3. Information of:  
Patient Name: \_\_\_\_\_ Medical Record # (if known) \_\_\_\_\_  
Birthdate and / or Soc Sec No. \_\_\_\_\_ Phone \_\_\_\_\_
4. Information is to be limited to the following **Dates of Treatment** (if applicable): \_\_\_\_\_
5. Information requested to be released:  Abstract  Operative Report  ER Record  
 History & Physical  Clinic Record  Discharge Summary  Admission Record  
 Physicians' Progress Notes  Nurses' Progress Notes  Other \_\_\_\_\_
6. Purpose of release is at the request of the patient or:  Insurance or Other Payment  
 Medical Care  Other (explain): \_\_\_\_\_
7. This authorization Will expire 90 days from the date on which it was signed unless I specify a different time period.  
Expiration Date or Event: \_\_\_\_\_. I understand that I may revoke this authorization at any time by giving written notice. A revocation of this authorization will not apply to records already released in reliance upon the authorization. A photocopy of this signed authorization shall constitute a valid authorization.
8. I understand that once the above Information is disclosed, it may be re-disclosed by the designated recipient and the Information may no longer be protected by federal privacy laws and regulations.
9. Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on your signing this authorization.

Signature of Patient  
or Legal Representative \_\_\_\_\_ Date/Time \_\_\_\_\_

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

**Provide a copy to Patient/Legal Representative**

