ARKANSAS DEPARTMENT OF HUMAN SERVICES
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name: _____ **Client ID #:** _____
Mailing Address: _____ **Date of Birth:** _____
_____ **Case Head:** _____

I, _____ hereby authorize
(Client or Personal Representative)

_____ to disclose specific health information
(Name of Provider/Plan)

from the records of the above named client to: _____
_____
_____
_____
(Recipient Name/Address/Phone/Fax)

for the specific purpose(s): _____
_____
_____

Specific information to be disclosed: _____
_____

If you use "All Medical Records" this will include any and all written information DHS may have concerning your health care and any illness or injury you may have suffered, including, but not limited to, medical history, consultations, prescriptions, treatment, medical evaluations, x-rays, results of tests, and copies of hospital or medical records pertaining to you.

I understand that this authorization will expire on the following date, event or condition: _____
_____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, sexually transmitted diseases, alcohol abuse, drug abuse, psychological or psychiatric conditions, genetic testing, family planning, or womens, infant, & children (WIC) this disclosure will include that information.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization. A copy of this authorization shall be as binding as the original.

_____ _____ _____
(Signature of Client) *(Date)* *(Witness-If Required)*

_____ _____ _____
(Signature of Personal Representative) *(Date)* *(Personal Representative Relationship/Authority)*

NOTE: This Authorization was revoked on _____ _____
(Date) *(Signature of Staff)*

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REVOCATION SECTION

<u>COMPLETE ONLY</u> WHEN REVOKING THE AUTHORIZATON

I do hereby request that this authorization to disclose health information of _____
(Name of Client)

signed by _____ on _____
(*Enter Name of Person Who Signed Authorization)* *(Enter Date of Signature)*

be rescinded effective _____ I understand that any action taken on this authorization prior to the
(Date)

Rescinded date is legal and binding.

_____	_____	_____	_____
(Signature of Client)	*(Date)*	*(Signature of Witness)*	*(Date)*

_____	_____	_____
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*

The Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act. This letter is available in other languages and alternate formats.