INTERNAL MEDICINE DIAGNOSTICS
197 Hospital Drive, Suite B, Cherokee Village, AR – 72529
Ph - 870-257-5118 -- Fax - 870-257-6215

Authorization to Release or Obtain Health Information

Name:____ Requesting Date:__________________

Mailing Address/City/State/Zip:__________________________________ Date of Birth:______________

I authorize the release of the above named individuals medical records as directed:
Name of Facility/Clinician making disclosure: ☐ Internal Medicine Diagnostics ☐ Other ____________________________
Mailing Address/City/State/Zip Code:____
Telephone Number:___________________________ Fax Number:____

☐ **RELEASE Information TO** or ☐ **OBTAIN Information FROM**
(Place an "x" in the box that indicates if the information is being released OR requested)

Facilty/Clinician/Person:____
Mailing Address/City, State, Zip Code:____
Relationship:_______________ Telephone Number:_________________ Fax:_______________________

I understand that the information in my medical 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, and alcohol or drug abuse.

The **Purpose of this Authorization** is indicated in the box(es) below.*(Place an "x" in the box(es) that apply.)*
☐ Further Medical Care ☐ Personal ☐ Legal Investigation or Action
☐ Changing Physicians ☐ Research related treatment
☐ Creating health information for disclosure to a third party
☐ Other: (Specify) ____

I would like my records provided to: ☐ Self ☐ Other Authorized Person ______________________via (if not marked default is US mail): ☐ US Mail ☐ Fax ☐ Email ☐ CD or ☐ USB.
By selecting email I understand that any information sent via unencrypted email is not a secure method of transmission and cannot be protected by the provider. I also understand that my information could be intercepted and redistributed without my knowledge or permission.

I authorize the release of the following protected health information.
(Place an "x" in the box(es) that apply to the information you wanted released or you want to obtain.)
☐ Entire Record ☐ Physician Progress Reports ☐ Surgical Reports
☐ Prescriptions ☐ Immunizations ☐ Hospital Records
☐ Laboratory Reports ☐ Radiology Reports ☐ Other: _______________________

This authorization shall expire on _____________(date and event) if I fail to specify an expiration date or event, this authorization will expire in 90 days for the date it was signed..

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by the federal privacy laws or regulations.

I understand that the entity making the disclosure may be paid for the costs of copying information to be disclosed.

Signature of Individual or Personal Representative authorized by law ________________________ Date ______________

Witness Signature:____ Date ___________________________

FOR OFFICE USE ONLY:
Verified ID (copy of driver's license etc) ☐Pick up (who)____________ ☐ Mailed ☐ Faxed ☐ Other _______________________
Office Personnel: ____ Date: ____