BAXTER HEALTH
624 HOSPITAL DRIVE, MOUNTAIN HOME, AR 72653

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PLEASE PRINT)

Printed Name of Patient _____ Previous Name (if applicable) _____ Social Security Number _____

Date of Birth _____ Telephone Number _____ Date of Service _____ Medical Record Number _____

RELEASE INFORMATION TO: (Please be specific):

Provider/Organization: _____

Address: _____

Telephone #: _____ Fax #: _____

Person: _____

Address: _____

Telephone #: _____ Fax #: _____

INFORMATION TO BE RELEASED FROM:

☐ Baxter Health and subsidiary agencies ☐ Baxter Health Clinic (please specify clinic name(s)): _____

_____

The type of information to be disclosed is as follows (check the appropriate boxes and include other information where indicated:

☐ Pertinent Documents ☐ Complete Record ☐ Discharge Summary ☐ Consultation ☐ EKG (s) ☐ Pap Smear
☐ X-ray(s) ☐ Operative Report ☐ Pathology Report ☐ Lab Report (s) ☐ Other _____

1. This authorization will automatically expire on _____
(APPLICABLE DATE OR EVENT)
2. I understand Baxter Health may be paid for the cost of copying the information to be disclosed.
3. I understand that the information in my medical record may include information relating to any treatment for HIV/AIDS, alcohol and/or drug abuse, behavioral health, or psychiatric patient information.

Purpose of Disclosure: ☐ Personal Use ☐ Continued Care ☐ Legal Purposes ☐ Insurance Purposes
☐ Other: _____

I understand my refusal to sign this authorization will not affect my ability to receive treatment.

I understand that I may revoke this authorization in writing except to the extent that Baxter Health has already acted upon the authorization or in the case of other exceptions as stated in the Notice of Privacy Practices. I understand that I have a right to request and receive a Notice of Privacy Practices from Baxter Health.

I understand that Baxter Health employees and my attending physician and his or her associates who participate in my care cannot be responsible for confidentiality of information disclosed after said information has been released.

_____ _____
Signature of Patient or Representative Date

_____ _____
Witness Date

FOR HOSPITAL USE ONLY:

☐ Verified Identity (ex: driver's license, check signature, etc.) ☐ Picked up (who) _____ ☐ Mailed ☐ Faxed
Comments: _____
Hospital Personnel: _____ Date: _____