ARKANSAS HEART HOSPITAL®
1701 S. Shackleford Road
Little Rock, Arkansas 72211

ARKANSAS HEART HOSPITAL®
CLINIC
7 Shackleford West Blvd
Little Rock, Arkansas 72211

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient Name ______________________________ Date of Birth ______________

Address ______________________________ Social Security # ______________

Hospitalization Date(s) ______________________________ Medical Record # ______________

Failure to provide all information requested may invalidate this Authorization.

I authorize the use or disclosure of the above named individual's health information as described below. The following individual(s) or organization(s) are authorized to make the disclosure:

Name: **Arkansas Heart Hospital**
Address: 1701 S. Shackleford Rd., Little Rock, AR 72211
Phone: (501) 219-7000

Name: **Arkansas Heart Hospital Clinic**
Address: 7 Shackleford West Blvd., Little Rock, AR 72211
Phone: (501) 664-5860

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

- ❑ Latest History and physical
- ❑ Latest Discharge Summary
- ❑ Laboratory reports:________(give dates)
- ❑ EKG:__________ (give dates)
- ❑ Entire Record
- ❑ X-ray reports:___________(give dates)
- ❑ Other (please describe) ______________________________
- ❑ Latest Operative report(s)
- ❑ Pathology report(s)
- ❑ Consultation reports from:

____
(Supply doctor's Name)

I understand that the information in my health 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 treatment for alcohol and drug abuse.

The information identified above may be used by or disclosed to the following individual(s) or organization(s):

Name: ______________________________

Address: ______________________________ Phone #: ______________

This information for which I'm authorizing disclosure will be used for the following purpose:

______________ Continued Health Care
______________ My personal records
______________ Other (please describe): ______________________________

This authorization will expire (insert date) ______________________

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that once the above information is disclosed, the recipient may redisclose the information and federal privacy laws or regulations may not protect it.

I understand authorizing the use or disclosure of the information identified above is voluntary. I do not sign this form to receive treatment.

______________________________ ______________
Patient Signature or Legal Representative Date

____
If signed by legal representative, relationship to patient

______________________________ ______________
Signature of witness Date

Date Sent: ______________ Information Sent: ______________

TPS146 09/11