Date: _____ **ACCT # / PT # MR #:** _____

REQUEST TO RELEASE RECORDS / INFORMATION

INFORMATION TO BE RELEASED FROM:	**INFORMATION TO BE RELEASED TO:**
	New Directions Health and Wellness 5501 Pinnacle Point Drive Rogers, Arkansas 72758 Telephone 855-215-4667 FAX: 479-657-6315

1. **I hereby authorize the release of information from the medical records of:**

   Patient Name: _____ Phone Number: _____

   Address: _____

   _____

   Date of Birth: _____ Patient SSN: _____

   Provider(s):_____

   For these dates of service: From: _____ To: _____

2. **Records are to be:** ☐ Mailed ☐ Faxed

3. **Information to be released:** ☐ Copies of the record

____ Complete Medical Record	____ Operative Report	____ X-Ray Reports	____ Other:
	____ Electrocardiogram	____ X-Ray Original Film	_____
____ Discharge Summary	____ Cardiology studies	____ Copy of X-ray Film	_____
____ History and Physical	____ Laboratory		_____

4. **Purpose of Disclosure:** ☐ Continuing Medical Care ☐ Other_____

5. I, the undersigned, understand that this consent can be revoked at any time by submitting a notice in writing to the entity specified in the "Information to be Released From" section above, except to the extent that disclosure made in good faith has already occurred based on this consent. Unless revoked, this authorization will automatically expire six months from the date hereof.

6. Fees/charges comply with all laws and regulations applicable to release of information. Per Arkansas regulations, I agree to a copy fee of $0.50 each page for the first 25 pages, and $0.25 per page thereafter for copies of the medical record mailed to patients or personal representatives.

7. I, the undersigned, hereby authorize and consent to the inspection, copying and disclosure by the above named facility to the above-named company or persons, their representative agents, or to the bearer of this instrument, of any and all information, records documents, reports, clinical abstracts, histories and charts of every kind and description, including:

   ❑ psychological/psychiatric impairments, drug abuse and/or alcoholism, or Sickle Cell Anemia, Acquired Immune Deficiency Syndrome (AIDS), relating to the above-named patient's condition, care, confinement and/or treatment. _____ (initials)

8. I hereby release the physician and the hospital from all legal responsibility or liability that may arise from this act I have authorized.

9. I understand that New Directions will not condition treatment, payment, enrollment, or eligibility for benefits should I decline to sign this authorization.

10. I understand that information used or disclosed pursuant to an authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA Privacy Rules._____ (initials)

Date: _____ Patient / Representative Signature: _____

Relationship to patient: _____

Witness: _____

Patient I.D.