# Integrated Medical, PA

## Authorization to Release Medical Information

**Patient Name: ______________________________** **Date of Birth: __________________**
**Social Security Number: _____________________** **Phone Number: ________________**
**I am the Patient ___ Guardian___ Parent of Minor Child___** Personal Representative and herby authorize Integrated Medical to disclose medical information on the above named patient to **Release to**:
**(Name/ Facility): ___________________________________** **Phone Number: __________________________**
**Address: ___________________________________________________________________________**
**Purpose of disclosure: ______________________________________________________________**
**Date(s) of treatments requesting: ______________________________________________________**

**Information requested**: (Per Arkansas Code section 16-46-106 Medical Records Part A2, we have the right to charge a labor fee of $15.00, .50 cents per page up to 25 pages then .25 cents for each additional page and a copying fee of $3.00. If mailing records a postage fee will be added, and the CD of all imaging studies is $10.00, this fee is to be paid prior to receiving records)

_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

**_______ (initial)** ** It can take up to 2 (two) weeks for the clinic to complete this request. Once request is completed the clinic will contact you for the payment and coordinate on how you will receive your medical records. ***

I understand that this authorization will automatically expire 12 (twelve) months from the date of my signature. I also understand that this authorization can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this authorization. To cancel this authorization, send a written request to:

Integrated Medical
ATTN: Billing Department
593 Horsebarn Road, Ste 101
Rogers, AR 72758

**_____ (initial)** Any information in your medical records that you have or may have a venereal disease is made confidential by law and cannot be released without your permission except in limited circumstances, including release to persons who have had risk exposures, release pursuant to an order of the court or the Department of Health, release among health care providers involved in your care or release for statistical or epidemiological purposes. When such information is released, it cannot contain information from which you could be identified unless the identifying information is released to you, by an order of the court or Department of Health or by law. Information released may include alcohol and drug abuse records protected under the Code of Federal Regulations and Psychiatric records. Re-disclosure of alcohol and drug abuse records by the recipient is prohibited without specific authorization.

**Signature of Patient/Personal Representative: __________________________________ Date: ______________**
**If personal representative, describe your authority to sign for the patient: _______________________________**
**Signature of Witness: ________________________________________________________________________**

Proof of Identity: _____Drivers License or Other form of ID: ______________ (description of what was accepted)
Your health information that you have authorized to disclose may be subject to re-disclosure by the recipient and no longer subject to protection under the federal privacy regulations. ***Completed authorization to disclose medical information should be returned to: Integrated Medical, PA 593 Horsebarn Rd. STE 101 Rogers, AR 72758***