Authorization for Release of Protected and Confidential Medical Information and Records

This release is intended to comply with the provisions of the
Health Insurance Portability and Accountability Act (HIPAA)

Patient Name:_____

Date of Birth:_____ SSN:_____

1. I authorize the use or disclosure of the above-named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:

_____

Name of Individual/Organization

_____

Address **City** **State** **Zip Code**

3. The type and amount of information to be used or disclosed is as follows (include dates where appropriate):

☐ problem list
☐ medication list
☐ list of allergies
☐ immunization record
☐ most recent history and physical
☐ most recent discharge summary
☐ laboratory results from (date)_____ to (date)_____
☐ Xray and imaging reports from (date)_____ to (date)_____
☐ consultation reports from (doctors' names)_____
☐ entire record
☐ other

4. _____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.

5. This information may be disclosed to and used by the following individual or organizations:

   Federal Public Defender, Eastern District of Arkansas
   The Victory Building
   1401 W Capital Avenue, Suite 490
   Little Rock, Arkansas 72201

   For the purpose of legal **proceedings in Federal District Court, including related legal actions.**

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the health information provider. I understand that the revocation will be effective upon its receipt by the person(s) I have authorized to release the information but will not apply to information that has already been released in response to this authorization.

7. I understand that authorizing the disclosure of this health information is voluntary and I can refuse to sign this authorization. I understand I may inspect or copy the information to be used or disclosed, as provided in 45 CFR § 160, et. seq. including 45 CFR § 164.524. I understand that if this information is disclosed to a third party, the information may be redisclosed by the person or entity that receives this information and may no longer be protected by federal privacy regulations.

8. This authorization will expire one year from _____or upon conclusion of legal proceedings.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to Patient Signature of Witness