ARKANSAS DEPARTMENT OF HEALTH
AUTHORIZATION TO DISCLOSE OR RELEASE HEALTH INFORMATION

(1) Client Name: _____ Client ID #: _____
Mailing Address: _____ Date of Birth: _____
_____

This form is to be used by clients of the Arkansas Department of Health ("ADH") to authorize ADH to **disclose** the client's health information to the client, the client's personal representative, or to another party. This form can be used by the client's medical providers to **release** medical information to the Arkansas Department of Health as designated by the client below.

NOTE: Select **disclose** if the information is being sent from ADH and select **release** if ADH is requesting medical information from provider.

(2) I, _____ hereby authorize the Arkansas Department of Health (ADH) to:
Disclose specific health records of the above named client to:

- ☐ Myself (the above named client) or my Personal Representative
- ☒ Third party listed below:

(Recipient Name/Address/Phone/Fax)

Community Preschool Phone: 479·452·9201 x 31
9201 Dallas Street Fax: 479·452-9220
Fort Smith, AR 72903

For the specific purpose(s): ☐ At the request of the Client ☐ Copy to Client ☐ Inspection by Client
☒ Other purpose (list):
enrollment of child in childcare center

(3) Specific information to be **disclosed** from ADH: ☐ All Medical Records ☒ Other (list):
Immunization Records

(4) I, N/A hereby authorize _____ (my medical provider)
to **Release** specific information **to ADH:**

- ☐ History, Physical, and Progress Notes
- ☐ Biopsy and Surgical Pathology Reports
- ☐ Maternity/Post Delivery Records
- ☐ Mammogram and Pap Reports
- ☐ Date and Type of Treatment
- ☐ Other (list):
- ☐ Lab Work, Pap Slides or Specimens
- ☐ Tumor Size and Stage

N/A

NOTE: "All Medical Records" includes any and all written information ADH may have concerning my health care and any illness or injury I may have suffered, including, but not limited to, medical history, consultations, prescriptions, treatment, medical evaluations, x-rays, results of tests, and copies of hospital or medical records pertaining to me.

(5) I understand that this authorization will expire on the following date, event or condition: upon child's exit from center or revocation

I understand that if an expiration date or condition is not stated above, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, sexually transmitted diseases, alcohol abuse, drug abuse, psychological or psychiatric conditions, Women, Infant, & Children (WIC) services, genetic testing, or family planning, this disclosure **will** include that information.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization. A copy of this authorization shall be as binding as the original.

(6) Signatures:

(Signature of Client)	(Date)	(Witness - if available, not required)
(Signature of Personal Representative)	(Date)	(Personal Representative Relationship/Authority)

NOTE: This Authorization was revoked on: _____ *(Date)* _____ *(Signature of Staff)*

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REVOCATION SECTION

I do hereby request that this authorization to disclose health information of _____ *(Name of Client)*

signed by _____ *(Name of Person Who Signed Authorization)* on _____ *(Date of Signature)*

be rescinded effective _____ *(Date)* I understand that any action taken on this authorization prior to the rescinded date is legal and binding.

(Signature of Client)	(Date)	(Witness - if available, not required)	(Date)
(Signature of Personal Representative)	(Date)	(Personal Representative Relationship/Authority)	

NOTE: Sections 1 thru 6 MUST be completed in order for Authorization to be valid.