Beebe Healthcare Medical Group

Outside Record Release or Disclosure of Health Information

Please Print Clearly

Patient Name: _____ Telephone: _____

Date of Birth: _____ Social Security Number: _____ - _____ - _____

Address: _____

	Records to be Released From:	Records to be Released To:
Name:		
Address:		
Telephone:		
Fax:		

PLEASE SEND <u>ONLY</u> THE INFORMATION CHECKED BELOW. CIRCLE NA IF NOT AVAILABLE.

- ❑ ENTIRE CHART (NA)
- ❑ VACCINE LIST (NA)
- ❑ LAST OFFICE NOTE (NA)
- ❑ ALL TESTING FROM PAST 2 YEARS (NA)

REASON FOR REQUEST: ❑ Transfer of Care ❑ Other _____

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my authorization for these records to be released unless specifically excluded. My initials below indicate records EXCLUDED from this authorization. The following protected information is NOT authorized for release:

_____ Drug/Alcohol abuse/treatment and diagnosis
_____ HIV/AIDS diagnosis/treatment/testing
_____ Sexually transmitted disease
_____ Mental illness or psychiatric diagnosis/treatment

I understand I do not have to sign this authorization in order to obtain healthcare benefits (treatment, payment or enrollment) and that I may revoke this authorization in writing at any time except to the extent action has been taken in reliance on this authorization. I understand that the information authorized for disclosure (except drug and alcohol treatment records) may be subject to re-disclosure by the recipient listed above, at which time it may no longer be protected under federal HIPAA Privacy Rules.

Patient Signature: _____ Date: _____

THIS AUTHORIZATION WILL EXPIRE IN 90 DAYS