BAXTER HEALTH

624 HOSPITAL DRIVE, MOUNTAIN HOME, AR 72653
PHONE: 870-508-1292 | FAX: 870-508-1658

AUTHORIZATION TO RELEASE PATIENT INFORMATION

PLEASE PRINT CLEARLY

RECORDS REQUESTED FROM:

☐ Baxter Health (Main Hospital)
☐ Fulton County Hospital
☐ Baxter Health Ambulatory Surgery Center - Harrison
☐ Hospice of the Ozarks
☐ Clinic: _____

REQUESTED DATES/TYPES OF SERVICES/TREATMENTS:

PATIENT INFORMATION:

Name _____

DOB _____ SSN# _____

Address _____

City, State, Zip _____

Phone _____

SEND TO: ☐ Self ☐ Other ☐ Other Healthcare Facility

Name _____

Address _____

City, State, Zip _____

Phone _____ Fax _____

Email _____

DELIVER BY:

☐ Email/Electronic (patients only) ☐ Mail
☐ Fax (other healthcare facilities only) ☐ Pick Up

CHECK BELOW FOR INFORMATION REQUESTED:

☐ Consultations ☐ Immunizations
☐ Operative Reports ☐ Complete
☐ Lab Results ☐ Pathology
☐ ED Records ☐ Mammography Film/CD
☐ Discharge Summary ☐ Mammography Reports
☐ Radiology Film/CD ☐ Radiology Reports
☐ History & Physical ☐ Newborn Records
☐ Therapy Notes ☐ Other _____

PURPOSE FOR REQUEST

☐ Treatment ☐ Patient Request ☐ Billing/Claims ☐ Transfer ☐ Legal ☐ Other _____

1. This authorization is voluntary. I can inspect or copy the protected health information to be used or disclosed.
2. I understand that I may revoke this authorization at any time by notifying the facility in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
3. I agree to waive all claims against the facility for the release of requested information.
4. I understand that if I request that records be copied and sent to me that the facility will make a good faith effort to send those records to me in a reasonable amount of time.
5. I understand that if the persons or entities to which I am asking that the provider disclose this information are not covered by Federal Privacy Regulations, then this information will no longer be protected under Federal Privacy Law and could be subject to re-disclosure.
6. I understand that if I wish to have copies of records made, then the facility may assess a fee for copying the records or x-rays. I will be notified of the total amount due for copying and shipping the requested records; I agree that the facility will only send me the requested information once it has received payment in full for those costs. I can inspect or copy the protected health information to be used or disclosed.
7. I understand that Baxter Health cannot condition admission to the facility upon my providing this authorization.

I understand that once information is released to the above named person or persons, my information may be subject to re-disclosure. I understand that any recipient to 42 CFR part 2 protected information must comply with part 2 protections and may not re-disclose the information except as permitted by part 2. 42 CFR §2.32.

I understand that my medical or billing record may contain information in reference to drug and/or alcohol treatment, psychiatric care, psychological care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing, reproductive health, status and/or treatment, and/or other sensitive information, and I agree to its release. I understand that if I authorize the release of drug and alcohol abuse treatment records that those records are protected by Federal Law.

_____ _____ Identification Verified
SIGNATURE DATE ☐ Yes ☐ No

_____ _____
PRINTED NAME OF PERSON MAKING REQUEST RELATIONSHIP IF NOT PATIENT

DO NOT DOCUMENT BELOW THIS LINE

* R E L O F I *

Patient Label