



HealthStar Physicians of Hot Springs PLLC  
1661 Airport Road, Suite D  
Hot Springs, AR 71913  
Phone: 501.625.7500 | Fax: 501.625.7777

## AUTHORIZATION TO RELEASE MEDICAL RECORDS

*Complete and return to HealthStar Physicians of Hot Springs via fax, mail, or drop-off at the address above.*

### SECTION A. Patient Information

Patient Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

SECTION B. Authorization: I hereby authorize HealthStar Physicians of Hot Springs located at the address above to release or obtain my Protected Health Information (PHI) as indicated: ☐ Release to ☐ Obtain from

Provider Name/Facility: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

SECTION C. Information Requested: (Check all that apply) ☐ Complete medical record ☐ Most recent office note  
☐ Radiology report ☐ Lab results ☐ Billing record ☐ Mental/behavioral health notes\*  
☐ Immunization records ☐ Other (specify): \_\_\_\_\_

Date range: \_\_\_\_\_ through \_\_\_\_\_

*\*Release of mental health, substance use, or HIV-related records may require additional authorization.*

SECTION D. Method of Delivery: ☐ Patient pick-up ☐ Fax ☐ Mail

SECTION E. Acknowledgments and Signature: I understand and agree with the following statements.

- This authorization will expire one year from the date signed, unless revoked earlier;
- I may revoke this authorization at any time in writing, except to the extent that action has already been taken;
- HealthStar may charge a reasonable, cost-based fee for copies of my records;
- And, once my information and records leave HealthStar, they may no longer be protected under HIPAA.

Patient or Legal Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name (if not patient): \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Legal documentation of authority attached (if applicable): ☐ Yes ☐ No

### FOR OFFICE USE ONLY

Verified by: \_\_\_\_\_ Date Received: \_\_\_\_\_

Method Verified: ☐ ID ☐ DOB/Address match ☐ Other \_\_\_\_\_

Completed by: \_\_\_\_\_

Date Completed: \_\_\_\_\_

Invoice #: \_\_\_\_\_ Amount: \$ \_\_\_\_\_

Paid by: ☐ Cash ☐ Check ☐ Card

Records sent by: ☐ Fax ☐ Mail ☐ Pickup Date Sent: \_\_\_\_\_

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