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)

_____
_____
_____
_____

For the specific purpose(s): ☐ At the request of the Client ☐ Copy to Client ☐ Inspection by Client
☐ Other purpose (list):

_____
_____

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

_____
_____

(4) I, _____herebv authorize_____(my medical provider) to **Release** specific information **to ADH:**

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

_____

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: _____

_____

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*)

ARKANSAS DEPARTMENT OF HEALTH
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

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.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION (AS-4000)

(See Memorandum No. 08-40, Subject: Revised Authorization to Disclose or Release Health Information (AS-4000)

PURPOSE

A dual form to authorize ADH to disclose the client's health information to the client, the client's personal representative, or to another party as designated by the client and to authorize the client's medical provider to release medical information to the Arkansas Department of Health.

USED BY

Health Department employees.

EXPLANATIONS AND DEFINITIONS

(1) Client Name through Date of Birth:	Self-explanatory.
(2) I, _____...:	Client or client's personal representative inserts his/her name.
Myself:	Check if client is releasing information to himself/herself or his/her personal representative.
Third party listed below:	Check if client is releasing information to anyone other than client or client's personal representative. List the name and address and phone/fax number, if known, of the party the client designates to receive health information.
For the specific purpose(s):	
At the request of the Client:	Check if the client initiates the authorization and does not, or elects not to, provide a statement of purpose.
Copy to Client:	Check when the release of information will consist of copies provided to the client or the client's personal representative.
Inspection by Client:	Check when the client or the client's personal representative only wants to view the client's health information.

Other purpose:	Check when the client's health information is being disclosed for other purposes. Provide a description of the other purpose for disclosure of the client's health information.
(3) Specific information to be disclosed:	
All Medical Records:	Check if the client or the client's personal representative intends for all medical records on file to be disclosed.
Other:	Check if the client or the client's personal representative intends for only a portion of the medical record to be disclosed. Provide a description of the specific information to be disclosed.
(4) I _____ hereby authorize _____:	Client or client's personal representative inserts his/her name followed by name of medical provider client is requesting records to be sent to ADH.
History, Physical and Progress Notes through Tumor Size and Stage:	Check for records to be released.
(5) I understand that this authorization...:	Provide a date, event or condition upon which the authorization will expire.
(6) Signatures:	
Signature of Client:	Self-explanatory.
Date:	Date of signature.
Witness:	Signature of person witnessing execution of this authorization. Note: A witness is not required if one is not available.
Signature of Personal Representative:	Self-explanatory.
Date:	Date of signature.
Personal Representative Relationship/Authority:	Self-explanatory.

NOTE: This Authorization was revoked on:

Date: Date of signature.

Signature of Staff: If or when this authorization is revoked, the ADH staff who administered the revocation of this authorization signs here.

REVOCATION SECTION

Name of Client: Self-explanatory.

Name of Person Who Signed Authorization: Self-explanatory.

Date of Signature: Self-explanatory.

Date: Enter the date the revocation is to be effective.

Signature of Client: Self-explanatory.

Date: Date of signature.

Witness: Signature of person witnessing execution of this revocation of authorization.

Date: Date of signature.

Signature of Personal Representative: Self-explanatory.

Date: Date of signature.

Personal Representative Relationship/Authority: Self-explanatory.

MECHANICS AND FILING

The Local Health Unit Administrator/In-Home Services Administrator/designee (or PHN/HHN if LHU Administrator is not a PHN/HHN) aids the client or client's personal representative in completing the Authorization to Disclose Health Information (AS-4000).

FINAL DISPOSITION

Authorization to Disclose Health Information (AS-4000)

Document	Office	Retention	Scan	
			Yes	No
Original	Work Unit	Destroy when medical record is destroyed, OR Scan when medical record is scanned.	X	X
Copy	Client	None.		X
Copy	ADH Privacy Officer/ Program Consultant	None.		X