JOHNSON REGIONAL MEDICAL CENTER

AUTHORIZATION TO RELEASE AND/OR RECEIVE RECORDS

Phone: _____ **Fax:**_____

Patient Name: _____ **DOB:** _____

Address: _____

SSN: _____-_____-_____ **Phone:** _____

I hereby authorization Johnson Regional Medical Center to:

□ **Release copies of billing or medical records to the following persons or entities**

□ **Receive copies of billing or medical records from the following persons or entities**

_____

_____

Information may be released in writing, verbally, or by video, fax, photocopy or microfilm

NOTICE TO PATIENT/PATIENT REPRESENTATIVE: If the recipient of the information disclosed pursuant to this authorization is not a health care provider, health plan or health care clearinghouse, the information may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws and regulations.

The information will be obtained and/or disclosed for the following reasons:

- □ **Treatment/Continuity of Treatment**
- □ **AT THE REQUEST OF THE INDIVIDUAL**
- □ **Marketing**
  JRMC will / will not (cross out one) receive compensation, whether monetary or otherwise, as a result of the use or disclosure of this information for marketing purposes.
- □ **Legal Reasons**
- □ **Assessment & Evaluation**
- □ **Other (Specify):**

This authorization will expire: □ **Ninety (90) days from the date of the signature below,**
Or □ **Other:** _____

This authorization may be revoked by notifying the Johnson Regional Medical Center in writing addressed to:

Privacy Officer
Johnson Regional Medical Center
1100 East Poplar Street
Clarksville, AR 72830

NOTE: Protected health information may already have been disclosed before the revocation is received. If so, the revocation will be effective only as of the date it is received by Johnson Regional Medical Center.

Patient Signature: _____ **Date:** _____

Personal Representative's Signature: _____ **Date:** _____

_____
Personal Representative's Relationship/Authority

This authorization is voluntary. A refusal to sign will not affect the patient's ability to obtain treatment, payment, or, if applicable, enrollment in a health plan or eligibility for benefits.