# Authorization/Consent for Release of Information

**Patient Name:**___________________________________

**Date of Birth:**__________________ **Social Security Number:**__________________

**I hereby authorize:**

☐ Methodist Behavioral Hospital/Methodist Counseling Clinic
(Acute and Sub-Acute/ School based programs/Clinics)
1601 Murphy Drive
Maumelle, AR 72113
Ph #: 501. 803.3388/Fax: 501.325.1387

☐ AR C.AR.E.S
2002 South Fillmore
Little Rock, AR 72204
Ph #: 501. 661-0720/Fax: 501.325.1387

☐ Methodist Children's Home
(Group Homes/Day Treatment/Emergency Shelter/
Fillmore RTC/Therapeutic Foster Care)
2002 South Fillmore
Little Rock, AR 72204
Ph #: 501.661.0720/Fax: 501.325.1387

☐ (Dacus RTC)
211 Church Street
Bono, AR 72416
Ph #: 870.932.8880/Fax: 870.336.7307/501.325.1387

to disclose and/or to obtain medical records to/from: ____________________________
(Name & Address of Person/Organization)

If known, document the following:

Contact Person: ______________________ Phone #: ______________ Fax #:____________

Email Address: ______________________ ☐ Yes ☐ No

| **TREATMENT DATES:** ☐2006 ☐2007 ☐2008 ☐2009 ☐2010 ☐2011 | **PURPOSE OF DISCLOSURE** | | | |
|---|---|---|---|---|
| ☐2012 ☐2013 ☐2014 ☐2015 ☐2016 ☐2017 ☐2018 ☐2019 ☐2020 **(CHECK ALL THAT APPLY)** | | Continuity of Care | | School |
| Other:____________________ (If month, date and/or year is known document on Other) | | Coordination of Services | | Reimbursement |
| | | Medical | | Other |

**I CONSENT ONLY TO THE RELEASE OF INFORMATION OR TREATMENT RECORDS AS SPECIFIED:**

| | | | | | |
|---|---|---|---|---|---|
| | Initial Assessment | | Case Management | | Speech/Language |
| | Initial Treatment Plan | | Consultations | | Hearing Assessments |
| | Treatment Plan Review | | School Reports/IEP | | Admission Notes |
| | Physical Exams | | Laboratory Reports | | Radiology Report/EEG |
| | Psychological Eval | | Discharge Summary | | Other (Specify): Applications for admission to orphange |

**AND/OR**

| | **BASIC REFERRAL PACKET – (PLEASE CROSS OUT ANY INFORMATION NOT WANTING TO BE RELEASED OR OBTAINED.)** | |
|---|---|---|
| Discharge Info Form | Assessments (All) | Physician Discharge Summary |
| Therapist Discharge Summary | H&P/Psychiatric Evaluation | Master Treatment Plans/Reviews |
| Physician Discharge Orders | Discharging Medication Form | |

**Pharmacogenetic lab results** are to assist in managing the treatment for a current condition, disease, illness, impairment, symptom or disorder. I authorize to release this information:

Pharmacogenetic lab: ☐ Yes ☐ No ☐ NA

**I ALSO AUTHORIZE RELEASE OF INFORMATION REGARDING:**

| **Alcohol and/or Substance Abuse** | **HIV/AIDS or other communicable disease** |
|---|---|

**NOTICE TO RECIPIENTS OF ALCOHOL AND/OR ABUSE SUBSTANCE INFORMATION:** This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal Rule prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that a photocopy of this release will give the same authorization as the original. I understand that once disclosed the information will no longer be private and may no longer be protected by federal privacy laws and regulations. I understand by affixing my name that Methodist may have **VERBAL CONTACT with the above-named organization/person.** I understand that I may revoke this consent in *writing* at any time, but such revocation shall have no effect on disclosures previously made. Unless I revoke this authorization prior to its expiration, the authorization to release information will automatically expire 90 (ninety) days after the patient's discharge from Methodist or: ☐ 90 days from the date of my signature. I, the undersigned, understand I am releasing the above information for the stated purpose of my own free will. I understand that by selecting "Yes" in the email address I am consenting that MFH may disclose PHI via encrypted email to the recipient. I attest that this consent was **totally completed** prior to affixing my signature.

______________________ ______________ ______________________
Signature of Parent/Guardian Date Relationship to Patient

______________________ ______________________
Witness (1) Witness (2)

If verbal consent print name of Parent/Guardian who gave consent: ______________________