



### Authorization to Release Medical Records

I hereby authorize Keystone Family Clinic to transfer, release, or obtain information on:

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Patient information is needed for:**

- Continuation of Medical Care     Personal Use     school
- Legal Purposes     insurance     other: \_\_\_\_\_
- SS/Disability     Military    \_\_\_\_\_

**Information to be Released:**

- Complete Medical Record:** Including office visits, lab results, hospital records, consultations, radiology reports, diagnostic testing, operative reports, etc. PLEASE NOTE: This may include such things as testing for drugs/alcohol, communicable diseases (including HIV) and/or psychiatric diagnosis.
- Lab/path reports     Office Visit Notes
- X-ray reports/images     Other: \_\_\_\_\_

**Method of Disclosure:**

Release Medical Records **FROM:**

name: \_\_\_\_\_

address: \_\_\_\_\_

\_\_\_\_\_

fax: \_\_\_\_\_

Release Medical Records **TO:**

Keystone Family Clinic

9207 HWY 71 S. STE #9

Fort Smith, AR 72916

p. 479-434-6140    f. 479-434-6144

I understand I have the right to refuse to sign this form, and that I may revoke my authorization at any time (except to the extent that the information has already been released). My information could be re-disclosed by the recipient, and the federal HIPAA Privacy Rule may no longer protect it. This authorization will automatically expire one (1) year from the date of this request. Refusal to sign this form will not affect my ability to obtain treatment or insurance payment or eligibility for benefits.

Patient/Guardian/Executor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_