KEYSTONE Family Clinic

11808 Hwy. 71 S.
Fort Smith, AR 72916
phone. 479-434-6140
fax. 479-434-6144

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

11808 Hwy. 71 S.

Fort Smith, AR 72916

fax: 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: _____ Witness _____