Arkansas Children's Hospital
Health Information Management
1 Children's Way Slot 109
Little Rock, Arkansas 72202
Release of Information
501−364−1268 Fax: 501−364−3968

For Official Use Only: MR#: _____ Acct #: _____

AUTHORIZATION TO RELEASE HEALTH INFORMATION TO SCHOOLS

ALL ELEMENTS ARE REQUIRED PRIOR TO INFORMATION BEING RELEASED

Patient Name: _____ Date of Birth: _____

1. Who is authorized to disclose the information? **Arkansas Children's Hospital AND Healthcare providers and those providing health services (school nurse, occupational therapist, speech therapist, physical therapist, etc.) within _____ School District**

2. Who is authorized to receive the information?

Arkansas Children's Hospital

Arkansas Children's Hospital
#1 Children's Way Slot 109
Little Rock, Arkansas 72202

AND

Healthcare providers and those providing health services within _____School District
(please include patient's school address below)

_____
_____
_____, _____ _____

3. The specific information to be requested or released is:

List the dates of service:

❑All ❑__/__/____ to ___/__/____ ❑HOLD for pending appointment

❑Discharge Summary
❑History & Physical
❑Discharge Instructions
❑ ER Report
❑ Clinic Reports
❑ Treatment Action Plans
❑ Other: _____

4. The information is needed for:
Continuity of Care and any necessary preparation or instruction needed in the school environment

5. I understand that if the person or entity that receives the information is not a covered entity under the federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

6. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used/disclosed under this authorization.

7. I understand that I may revoke this authorization in writing at any time by delivering a copy of my revocation to Arkansas Children's Hospital except to the extent that action has been taken in reliance on this authorization. This authorization expires: 1 year from date signed.

8. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and/or treatment for alcohol and drug abuse.

_____ _____
Signature of Patient or Representative Date

_____ _____
Phone Number Relationship to Patient

Witness:_____Phone Number:_____Date:_____