MENA REGIONAL HEALTH SYSTEM
AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____

☐ Mena Regional:
311 N. Morrow
Mena, AR 71953
Fax: 479-243-2455

☐ Mena Surgical Clinic:
400 Crestwood Circle
Mena, AR 71953
Fax: 877-554-2501

☐ Mena Medical Associates:
1103 College Drive
Mena, AR 71953
Fax: 877-775-6761

I authorize and request MENA REGIONAL HEALTH SYSTEM to:

_____ **RELEASE** information to: _____ **OBTAIN** information from:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I authorize the following PHI to be released from my medical record (s):

☐ Radiology Reports
☐ Radiology Images**
☐ Laboratory Reports
☐ ER Report
☐ History and Physical
☐ Discharge Summary
☐ Operative Note
☐ Entire Record
☐ Clinic Notes
☐ Billing
☐ Other _____

Covering the period of health from: _____

Purpose for requesting information:

☐ Continuity of Care ☐ Legal* ☐ Insurance*
☐ Other* _____

_____ _____
Patient or Personal Representative Signature **Date**

_____ _____
Printed Name of Patient of Personal Representative **Description of Personal Representative's Authority**

PHI may include reports relating to mental health care communicable diseases, HIV/AIDS, and/or treatment of alcohol/drug abuse. I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to Health Information Management Department. Revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date/event/condition, this authorization will expire 60 days from the date signed. I understand that any disclosure of information carries with it the potential of re-disclosure and information may not be protected by the Health Insurance Portability and Accountability Act of 1996. I understand that your provider will not deny you treatment if you do not sign this form. I may inspect or obtain a copy of my PHI.

OFFICE USE ONLY

Identity of Requestor Verified: ____ Photo ID ____ Matching Signature ____Other_____

Verified by: _____

*5 pages or less is free. Charge per page according to the Arkansas Code Section 16-46-106 (Pages 6 – 25 is 50 cents per page, 26+ is 25 cents per page). Radiology discs are $5.00. **Radiology Images are not encrypted.