Arkansas Medical Foundation

for

The Physicians Health Committee

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AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION FROM AMF-PHP

I, _____
(Please print Participants Name)

Home Address: _____

(Street, City, State, Zip)

Office Address: _____
(Street, City, State, Zip)

Home Phone: _____

Office Phone: _____

I ACKNOWLEDGE RECEIPT OF AMF'S PRIVACY POLICY AND HEREBY AUTHORIZE:

The ARKANSAS MEDICAL FOUNDATION PHYSICIANS HEALTH PROGRAM'S STAFF TO

DISCLOSE/RELEASE

(Please check all that are appropriate)

- ❑ Copy(ies) or summary(ies) of information pertinent to AMF-PHP participation, compliance, aftercare, along with other treatment/assessment facility's information/recommendations.
- ❑ To Re-Disclose _____
- ❑ Other _____

TO: _____

PURPOSE:

- ❑ To facilitate case management and advocacy efforts
- ❑ Other _____

Participant's Signature: _____

Date of Signature: _____

EXPIRATION: THIS CONSENT IS SUBJECT TO WRITTEN REVOCATION AT ANY TIME EXCEPT TO THE EXTENT THAT THE AMF PHP WHICH IS TO MAKE SURE THIS DISCLOSURE HAS ALREADY TAKEN ACTION IN RELIANCE ON THIS AUTHORIZATION/CONSENT. ONCE REDISCLOSED, THE INFORMATION RECIPIENT(S). POTENTIALLY MAY RE-DISCLOSE TO PERSONS/ENTITIES NOT SUBJECT TO HIPAA. THE AMF-PHP RESERVES THE RIGHT TO CHANGE ITS PRIVACY PRACTICE. THE PARTICIPANT MAY REQUEST A RESTRICTION OF THE USE.OF COVERED INFORMATION , BUT, UNLESS IT AGREES, THE AMF-PHP IS NOT REQUIRED TO HONOR THAT REQUEST. IF NOT PREVIOUSLY REVOKED, THIS CONSENT WILL TERMINATE THIRTY (30) DAYS AFTER SUCCESSFUL COMPLETION OF THE AMF- PHP PARTICIPATION OR AFTERCARE CONTRACT UNLESS ANOTHER DATE IS INDICATED: ___/___/____.