Arkansas Medical Foundation

for

The Physicians Health Committee

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Medical Director	Executive Director	Program Coordinator

AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION TO 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:

____
(Name or description of facility or program making the disclosure)

TO DISCLOSE/RELEASE

- ❑ Treatment and discharge summary reports including recommendations
- ❑ Evaluations including urine results and reports including recommendations
- ❑ Clinical Updates
- ❑ To Re-Disclose
  (Note: Once re-disclosed, information may not be HIPAA protected.)
- ❑ Other ____

TO: The AMF-PHP and its staff and applicable RAM Team.

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: ___/___/____.