Arkansas Medical Foundation

for

The Physicians Health Committee

10 Corporate Hill Drive, Suite 150, Little Rock, AR 72205
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AUTHORIZATION FOR RELEASE OF INFORMATION FROM AMF

I, _____ hereby authorize:

Arkansas Medical Foundation
10 Corporate Hill Drive, Suite 150
Little Rock, AR 72205

To disclose/release

- Copies or summaries of information pertinent to AMF participation, compliance, aftercare, along with other treatment/assessment facility's information/recommendations
- Other_____

_____ _____
Name Organization

_____
Address

_____
City State Zip

(___)_____ (___)_____ _____
Phone No. Fax No. Email

Purpose:

- To facilitate case management and advocacy efforts
- Other_____

_____ _____
Signature Date

This information has been disclosed to you from records protected by federal confidentiality rules (42CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for release of information is **NOT** sufficient for this purpose.