Arkansas Medical Foundation

for

The Physicians Health Committee

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ hereby authorize and request that the AMF release to:

_____ _____
Name Organization

_____
Address

_____
City State Zip

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

The following information is protected by state and federal law:

( ) Compliance Letter – includes effective dates of current contract, compliance with random drug screening program, (whether drug screen results are positive or negative) and compliance with meeting attendance requirement.

_____ _____ _____
Printed Name Signature Date

Witnessed By: _____ 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.