Department of Transformation and Shared Services
Governor Asa Hutchinson
Secretary Amy Fecher

Phone: (501) 682-9656 **Toll Free: (877) 815-1017** **Fax: (501) 682-1168** **http://www.transform.ar.gov**

Authorization to Release Information

This form is used to release your protected health information as required by federal and state privacy laws. Your authorization allows EBD (ARBenefits) to release your protected health information to a person or organization that you choose. You can revoke this authorization at any time by submitting a request in writing to EBD. Revoking this authorization will not affect any action taken prior to receipt of your written request.

Member Information: (individual whose information will be released)

Name:_____Member ID #:_____Date of Birth: _____

Address:_____Telephone #:_____

I authorize EBD (ARBenefits) to release my protected health information as described below

Recipient: (Person or organization that will receive your information)

Person's Name or Organization: _____

Address:_____Telephone #:_____

Person's Name or Organization: _____

Address:_____Telephone #:_____

Description of the Information to be Released: (What type of information will be released)

☐ Entire Health Record

☐ Other, please describe _____

This authorization will expire (Check ONLY ONE Box):

☐ When I revoke this authorization.

☐ Upon the following date, event, or condition: _____

If I fail to specify an expiration date, this authorization will expire in twelve (12) months from the date of this signing.

I understand that this authorization to release information is voluntary and is not a condition of enrollment in ARBenefits Health Plan, eligibility for benefits, or payment of claims. I also understand that once the information is disclosed pursuant to this authorization, it may be disclosed by the recipient and the information may not be protected by federal privacy regulations. I understand that the information in my health record may include information relating to sexually transmitted diseases, behavioral or mental health services, and treatment for alcohol and drug abuse.

By signing below, I authorize the release of my protected health information as described above.

_____
Signature of Member or Legal Representative

_____
Printed Name of Member or Legal Representative

_____**Date**

For EBD Use Only

Member ID#: _____

Completed By _____