SPRINGWOODS
BEHAVIORAL HEALTH

PATIENT REQUEST FOR HEALTH INFORMATION

Patient Name: _____ Birthdate: _____

Date(s) of Treatment: _____ Phone: _____

Information to be released FROM: Name/Agency: Springwoods Behavioral Health

Address: 1955 W. Truckers Drive

Fayetteville AR 72704

Phone: 479-973-6000 Fax: 479-973-6021

Information to be mailed TO: Name/Agency: _____

Address: _____

_____

Phone: _____ Fax: _____

E-mail or FAX TO: _____

Purpose for Release:

☐ Continuity of Care ☐ Education Credit ☐ Legal Representation ☐ Other (specify) _____

Information to be Released:

☐ Dates of Hospitalization (only)	☐ Psychiatric Evaluation	☐ Educational Assessment	☐ Consultation Reports
☐ Discharge Summary	☐ Psychological Evaluation	☐ School Records	☐ Medication Records
☐ History & Physical Exam	☐ Aftercare Plan	☐ Lab Reports	☐ Physician Progress Notes

Other (specify): _____

I understand that information to be released may include information regarding drug abuse, alcohol abuse, psychological or psychiatric impairments, HIV and/or AIDS or physical conditions.

I certify this authorization is made voluntary. I understand that the information to be released is protected under state and federal laws and cannot be re-disclosed without my further written consent unless provided for by state and federal law.

I understand I may revoke this authorization at any time, except to the extent that action has already been taken. If not previously revoked, this consent will expire six months from date of signature.

Fees/charges comply with all laws and regulations applicable to the release of information. Per Arkansas regulations, I agree to a copy fee of $0.50 each page for the first 25 pages, and $0.25 per page thereafter + $15.00 processing fee for copies of the medical record.

_____ _____

Signature of Patient Date Signature of Parent/Guardian/Representative Date

_____ _____

Signature of Witness Date Relationship