CONSENT FOR REQUEST AND RELEASE OF PERSONAL AND HEALTH INFORMATION

PATIENT'S INFORMATION:

LAST NAME	FIRST NAME/MIDDLE INITIAL	DATE OF BIRTH
ADDRESS	CITY, STATE, ZIP CODE	PHONE NUMBER

THE FOLLOWING PERSON/AGENCY IS REQUESTED TO RELEASE THE SPECIFIED INFORMATION:	**DESCRIPTION OF INFORMATION TO BE RELEASED:**
Agency Name: ______________________ Contact: ______________________ Address: ______________________ City, State, Zip: ______________________ Telephone: ______________________ Fax: ______________________	**__ All Information Relevant to Consultation, Treatment or Diagnosis** **OR** __ Psychological / Educational Evaluation Results __ Psychological Treatment and Diagnostic Records __ Billing and Payment Records __ Medical, Health, or Developmental Information __ Psychological, Behavioral, Educational Information __ Other Information (specify):

THE PERSON OR AGENCY ABOVE IS BEING REQUESTED TO RELEASE MY CHILD'S INFORMATION TO:
Arkansas Families First, LLC 4004 McCain Blvd. Ste 203, North Little Rock, Arkansas 72116 Phone: 501-812-4268; Fax: 501-812-4286

REASON FOR RELEASE OF INFORMATION: __coordination/continuity of care __other (specify): ______________________

DATE(S) OF SERVICE COVERED BY THIS REQUEST: ____

VOLUNTARY: I know that I am not required to sign this consent form and that I will not be refused treatment if I do not sign this form. I can refuse to sign this consent form, although disallowing collaboration between involved parties may limit the quality of services I receive from any of the agencies.

LENGTH OF TIME: This consent will be valid from the date that I sign this form until ___________ (date). If no date is entered, the form will be valid until *the date that I terminate services* with Arkansas Families First, LLC.

WITHDRAWAL OF CONSENT: I know that I can withdraw this consent at any time. To withdraw my consent, I must send a written notice to the person or agency asked to release this information. The withdrawal will be valid as soon as the person or agency receives my notice, but will not apply to information that has already been shared after I signed the consent form and before receipt of the withdrawal notice.

SHARING OF INFORMATION: I know that my information may be shared more than once by the persons and/or agency(ies) listed above. The information may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It may still be protected by other State and Federal laws. Arkansas Families First, LLC is not responsible for further release of information by other agencies.

COPY: A copy of this consent form may serve as the original. I know that I have a right to obtain a copy of this consent form if I request one.

Signature:	Date:
Relationship to patient:	