State of Arkansas
Department of Finance
and Administration

EBD
Employee Benefits Division
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Little Rock, AR 72231-5610

Phone: (501) 682-9656 Toll Free: (877) 815-1017 Fax: (501) 683-0230 http://www.ARBenefits.org

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 ____

Expiration: (When this authorization will end)

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

System ID#: _______________

Completed By _____________