Attachment 1

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
OFFICE OF POLICY AND CERTIFICATION

Accreditation Organization Release of Information Consent

I, _____, hereby consent to the exchange of information between
CEO (or equivalent)

_____ and
Accrediting Agency

The Division of Behavioral Health Services, Policy and Certification Office, for the specific purpose of obtaining or sharing information relevant to RSPMI Provider Certification.

I consent to information regarding my agency's national accreditation or state certifications being released by facsimile (FAX) _____ Yes _____ No.

I understand that the information I authorize for release may include sensitive information. I understand that a facsimile of this consent is considered as valid as if it were the original.

_____ _____
Signature of CEO (or equivalent) Date

_____ _____
Signature of Witness Date