



**ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIFFERENTIAL RESPONSE PROGRAM
AUTHORIZATION FOR RELEASE OF INFORMATION**

Client Name: _____ CHRIS ID: _____
Mailing Address: _____ Date of Birth: _____

I, _____ hereby authorize
(Client or Personal Representative)

_____ to disclose specific information about my case to:
(Name of Provider)

_____ *(Recipient Name)* _____ *(Recipient Address)*

_____ *(Phone #)* _____ *(Fax #)*

for the specific purpose of: _____

Types of Information:
(Check all that apply)

- Mental Health Financial Social History Education
 Medical (specify): _____
 Other (specify): _____

I understand that this authorization will expire on the following date, event or condition: _____

I understand that if I do not specify an expiration date or condition, this authorization is valid for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the bottom of this form.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits. I further understand that I may request a copy of this signed authorization. A copy of this authorization shall be as binding as the original.

Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether or not the consent is signed by the client or his/her personal representative. HOWEVER I UNDERSTAND THAT IF I REFUSE TO CONSENT, THE FOLLOWING MAY HAPPEN: _____

_____ *(Signature of Client)* _____ *(Date)* _____ *(Witness-If Required)*

_____ *(Signature of Personal Representative)* _____ *(Date)* _____ *(Personal Representative Relationship/Authority)*

REVOCAION SECTION

I do hereby request that this authorization to disclose information of _____
(Name of Client)

signed by _____ on _____ be rescinded
(Name of Person Who Signed Authorization) *(Date of Signature)*

effective _____ . I understand that any action taken on this authorization prior to the
(Date)

rescinded date is legal and binding.

_____ *(Signature of Client)* _____ *(Date)* _____ *(Signature of Witness)*