



Arkansas Department of Human Services
CONSENT FOR RELEASE OF INFORMATION

TO: _____
Person or Agency

Address

City State Zip

Table with 4 rows: This section pertains to Release of Medical Information including treatment for drug and alcohol and for psychiatric conditions*; Dates of Hospitalization; Dates of Outpatient Care; Clinic or Chart Number if Known

This is your authority to release the requested _____ Specify Type of Information
information regarding _____, _____, _____, _____
First Middle Last SSN

to the Arkansas Department of Human Services or authorized representative listed below.**

_____ Date Signature of Applicant/Recipient or Authorized Representative and Title

_____ Witness Signature of Spouse/Relative if Applicable and Relationship

_____ County

Obtain original signatures on all copies. Worker may sign as witness.

*Complete only if Request is for Medical information.

**Note: Client's medical records become part of the client's file and may be reviewed by the client upon request unless the treating physician provides a written determination that disclosure of such information would be detrimental to the client's welfare (Re. Ark. Code Ann. 16-46-106).

If you need this material in a different format, such as large print, contact your DHS office.