



STATE OF ARKANSAS  
**Department of Finance  
 and Administration**

**EBD**  
 Employee Benefits Division  
 Post Office Box 15610  
 Little Rock, AR 72231-5610

Phone: (501) 682-9656 Toll Free: (877) 815-1017 Fax: (501) 682-2366 <http://www.state.ar.us/dfa/ebd>

**Authorization for Release of Health Information - Retirees**

Retiree Name: \_\_\_\_\_

Retiree Dependent Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone #: ( ) \_\_\_\_\_ - \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

I authorize the use or disclosure of the above-named individual's health information as described below:

The following individuals or organizations are authorized to make the disclosure:

**State of Arkansas - Arkansas Highway and Transportation Department**

The type and amount of information to be used or disclosed is as follows:

(check off appropriate item(s), and include other information, where indicated)

Retirement Department

- billing issues related to health or life premiums
- life insurance coverage
- medical insurance coverage
- Medicare information
- other: \_\_\_\_\_

Medical Compliance Department

- medical claim issues
- pharmacy claim issues
- medication list
- list of medical problems
- list of your medications
- medical records from your physician or specialist
- medical records from hospitalization
- other: \_\_\_\_\_
- Do you have any allergies? If so, please list: \_\_\_\_\_

This information may be disclosed to, and used by, the following individuals or organizations: (*providers, spouse, friends, etc.*)

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**See reverse side.**

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

**By my signature below, I authorize disclosures to and by EBD.**

This information is being disclosed for the following purpose:

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the EBD Privacy Officer (on the header address.) I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire on the following date, event or condition: \_\_\_\_\_

**If I fail to specify an expiration date, event or condition, this authorization will expire in twelve (12) months from the date of this signing.**

I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may be protected by federal privacy regulations.

I understand that I need not sign this form in order to ensure health care treatment, payment enrollment in my health plan, or eligibility for benefits.

\_\_\_\_\_  
Signature of Retiree, Retiree Dependent or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If signed by legal representative or dependent, print relationship to Retiree

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

I understand that the information in my health record may include information relating to sexually transmitted disease, behavioral or mental health services and treatment for alcohol and drug abuse.

**Retain a copy for your records and forward a copy to AHTD**