AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient:

Name of Patient/Previous Names

Birth Date

Street Address

City, State, Zip Code

Authorizes:

Name of Health Care Provider/Plan/Other

Street Address

City, State, Zip Code

Phone

Fax

Release of Protected Health Information To:

Name of Health Care Provider/Plan/Other

Street Address

City, State, Zip Code

Phone

Fax

Information to Be Released:

- ☐ Medical History, Examination, Reports
- ☐ Hospital Records Including Reports
- ☐ Allergy Records
- ☐ Consultations
- ☐ Surgical Reports
- ☐ Treatment or Tests
- ☐ Laboratory Reports
- ☐ Entire Record
- ☐ Immunizations
- ☐ X-ray Reports
- ☐ Prescriptions
- ☐ Other (Specify):

Purpose: for Need of Disclosure:

- ☐ Further Medical Care
- ☐ Insurance Eligibility/Benefits
- ☐ Legal Investigation or Action
- ☐ Changing Physicians
- ☐ Personal
- ☐ Other (Specify):

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses that must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

Rights with Respect To This Authorization:

Right to Inspect or Copy the Health Information to Be Used or Disclosed – I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Northwest Arkansas Clinic for Families. **Right to Receive Copy of This Authorization** – I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Refuse to Sign this Authorization** – I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw This Authorization** – I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Northwest Arkansas Clinic for Families. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

Expiration Date: This authorization is good until the following date(s) _____ or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Patient or Legal Representative: _____ Date: _____

(If signed by other than patient, state relationship and authority to do so.)

Witness: _____ Date: _____