The Woman's Clinic, P.A.
9601 Baptist Health Drive, Suite 1200
Little Rock, Arkansas 72205
Phone: (501) 664-4131 Fax: (501) 664-9470

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name:_____ DOB:_____ Social Security#:_____

Patient Address:_____

Contact #_____

I authorize the use and/or disclosure of my health information as described below:

1. Person(s) authorized to use **or** disclose **(circle one)** the information:_____
2. Name, Address, Phone # and Fax # of person(s) authorized to receive **or** release **(circle one)** information:

_____

3. Information to be released:

   _____Entire Medical Record _____Operative Reports _____Radiology Reports _____Consultation Reports

   _____Pathology Films _____Laboratory Reports _____Other Diagnostic Tests Other:_____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
5. The information will be used/disclosed for the following purpose:_____
6. I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by the HIPPA regulations.
7. I understand that The Woman's Clinic, P.A. may be composed for copying charges or labor costs incurred for disclosing this information.
8. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.
9. I understand that I may revoke this authorization in writing at any time by presenting my written revocation to The Woman's Clinic, P.A. I understand that the revocation will not apply to information that has already been released in response to this authorization. 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 (1) year.
10. I understand that I will receive a copy of this signed authorization.

Please be advised that an initial fee of $25.00 per request will be charged.

Signature of Patient or Representative:_____ Date:_____

Name of Personal Representative (if applicable):_____ Relationship:_____

Witness:_____