

Siloam Springs Women's Center

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the release of my medical information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider subject to federal or state regulations, the released information may no longer be protected by federal or state privacy regulations.

Patient's name: _____ Birth date: _____

I authorize SSWC to (check one) release information to or obtain information from:

Name of Facility or Person: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Portion of the medical record to be released: Specify dates of service: _____

Copy of complete record Radiology/Ultrasound Reports Laboratory Reports

Other _____

Portion of the medical record, if any, not to be released: _____

What is the purpose of the requested release?: _____

I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, enrollment in any health plan, or eligibility of benefits unless allowed by law. I understand that I have the right to request a copy of this form after I sign it.

I understand that if my medical record contains information which indicates the presence of a communicable or venereal disease, including, but not limited to, hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS), as well as mental health information, and/or records concerning treatment for alcohol and/or drug abuse, I agree to its release.

Authorization will expire in ninety (90) days, or (specify date or event): _____

I hereby affirm that I have read and fully understand the provisions of this form and consent to the disclosure of medical records for the purposes stated above. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any effect on any actions taken before receiving the revocation.

Signature of patient/patient's representative/agent (Form MUST be completed before signing)

Date of Signature

Printed name of patient's representative or agent

Relationship to the patient

SSWC USE ONLY: ID of Requestor Verified Photo ID; Matching signature; Other: _____

Information released mailed, given to patient, faxed or other _____

Information requested: Authorization mailed, faxed, or other _____

of pages copied: _____ Fee for copies _____

Request processed by: _____ Date: _____