The Center for Women

628 Hospital Drive, Suite 2A
Mountain Home, Arkansas 72653
(870) 425-7300 / (870) 425-4431 Fax / (870) 424-4164 Medical Records Fax

Authorization to Release Medical Information To The Center for Women

(PLEASE PRINT)

Patient Name: _____SSN#:_____ Date of Birth: _____

1. I authorize the release of the above named individual's medical records as directed below:

2. _____, (_____)_____-_____
(Name of Facility, Clinician, Practice (Entity) making disclosure) (Telephone Number)

   of _____
   (Address, City, State, Zip)

   is authorized to make the disclosure. Their fax number is **(_____)_____.**

3. The type of information to be disclosed is as follows:_____

_____

4. I understand that the information in my medical 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 alcohol or drug abuse.

5. The information identified above may be used or disclosed to the following individuals organization(s):

   Facility-Clinician-Person: **The Center for Women**

   628 Hospital Drive, Ste. 2A

   Mountain Home, AR 72653

   (870) 425-7300 Telephone #

   (870) 424-4164 Medical Records Fax #

6. This information for which I am authorizing disclosure **will be used for the following purpose**:
   ☐ Personal Use ☐ Continued Care ☐ Legal Purposes ☐ Insurance Purposes ☐ Other _____

The Center for Women

628 Hospital Drive, Suite 2A
Mountain Home, Arkansas 72653
(870) 425-7300 / (870) 425-4431 Fax / (870) 424-4164 Medical Records Fax

7. **I would like my records provided to** ☐ Me x Other person: **The Center for Women**

   via (if not marked default is US Mail): ☐US Mail ☐Fax ☐Email ☐Electronic format: (*indicate preference)*
   ☐CD ☐ USB drive or ☐ Other_____

   ***By selecting email I understand that any information sent via unencrypted email is not a secure method of transmission and cannot be protected by the provider. I also understand that my patient information could be intercepted and redistributed without my knowledge or permission**

8. I understand that I have a right to withdraw this authorization at any time. I understand that if I withdraw this authorization, I must do so in writing and give my written withdrawal to the entity making the disclosure. I understand that stopping this release will not apply to information that has already been released by this authorization. I understand that the withdrawal will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

9. **This authorization will expire**_____ (insert date or event). If I fail to specify an expiration date or event, this authorization will expire 90 days from the date it was signed.

10. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by the federal privacy laws or regulations.

11. 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 obtain a copy of any information used or disclosed under this authorization.

12. I understand that the entity making the disclosure may be paid for the costs of copying information to be disclosed.

_____ _____
Patient **OR** parent, guardian, authorized representative signature Date

_____ _____
Witness Signature Date

FOR OFFICE USE ONLY:
Verified ID (ex. copy of driver's license, check signature, etc.) Comments:_____
☐ Picked Up (who) _____ ☐ Mailed ☐ Faxed ☐ Other_____
Office Personnel: _____ Date: _____