FAX Form to: 501-278-2862 Medical Records: PH: 501-278-2800

SEARCY MEDICAL CENTER

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Patient Name: ______________________ Health Record No.: ______________

Date of Birth: ______________________ SSN: _______/_______/_______

I voluntarily authorize this clinic to release the protected healthcare information ("PHI") of the person above to:

Person/Company providing the Information:	Persons/Companies Receiving the Information:

Specific Information to be Released with Dates: ______________________

Purpose: a. If requested by the Patient/Patient's Personal Representative: At the request of the individual.

b. Other:(Must complete) ______________________

Section A. Must be completed if health plan insurer or health care provider has requested the information.

1. a. The purpose of this disclosure is: ______________________

   b. This disclosure will result in direct or indirect payment to the physician: YES__________ NO__________

2. The patient or personal representative must read and initial:

   a. I understand that my health care/treatment and the payment for my healthcare will not be affected if I do not sign this form.

   Initials:__________

   b. I understand that I may see and copy the information described on this form, if ask for it, and that I get a copy of this signed form.

   Initials:__________

Section B. Must be completed for all authorizations.

The patient or the patient's personal representative must read and initial the following:

1. I understand that this authorization will expire on ____/____/____ days or when the following event occurs:

   ______________________ **Initials:**__________

2. I understand that I have the right to revoke this authorization at any time by notifying the clinic in writing, but it won't affect the actions taken before the clinic received the revocation. I understand that my personal representative or I must sign and date the letter or revocation.

   Initials:__________

3. Once this clinic gives out this information I want released, I know that the clinic has no control over the information. The person or company authorized to receive the information might re-disclose it without my knowledge or approval. Federal and state laws would no longer protect the information.

   Initials:__________

4. I understand that treatment, payment, enrollment and benefits may not be conditioned upon my signing this authorization.

   Initials:__________

X______________________ ______________

Patient Signature/Patient's Personal Representative Date

If Personal Representative, explain the relationship or authority to act for the patient: ______________________

Section C:

IN ADDITION TO THE ABOVE GENERAL CONSENT, I ALSO WISH TO RELEASE ANY INFORMATION RELATING TO DRUG/ALCOHOL ABUSE, PSYCHIATRIC OR MENTAL HEALTH NOTES AND AIDS/HIV DIAGNOSIS AND TREATMENT. I UNDERSTAND AND I CAN REVOKE THIS AT ANY TIME IN WRITING. I AGREE TO RELEASE THE TREATING PHYSICIAN, THIS HEALTHCARE FACILITY AND ITS EMPLOYEES FROM ANY ACTION, CAUSE, RIGHT OR CLAIM OR LIABILITY WHATSOEVER FOR THE RELEASE OF THIS MEDICAL INFORMATION MADE IN GOOD FAITH.

X______________________

Patient/Personal Representative