St. Bernards CLOPTON CLINIC
The Heart of Great Medicine

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- ☐ Dr. Mohammed Al-Hajji
- ☐ Dr. Hania Al-Shahrouri
- ☐ Dr. John Ball
- ☐ Dr. Jeffrey O. Cohen
- ☐ Dr. Corey L. Diamond
- ☐ Dr. Chitharanjan Duvoor
- ☐ Dr. Clinton B. Edwards
- ☐ Dr. Veryl D. Hodges
- ☐ Dr. James Maxwell
- ☐ Dr. Joshua B. Morrison
- ☐ Dr. Claiborne L. Moseley
- ☐ Dr. Rebecca L. Osborne
- ☐ Dr. Ben E. Owens
- ☐ Dr. Revel Porter
- ☐ Dr. David Pyle
- ☐ Dr. Mark D. Sifford
- ☐ Dr. Rick Tate
- ☐ Dr. John W. Thompson

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

FROM/TO: (Circle one) CLOPTON CLINIC OF JONESBORO
300 CARSON ST.
JONESBORO, AR 72401

FROM/TO: _____
_____
_____

CONTACT PERSON: _____ CONTACT PERSON: _____

I hereby authorize the release of any and all records in your control or possession relation to the medical care of:

Patient Name _____ **SS#** _____ **DOB**_____ **Phone #**_____

This request includes but is not limited to:

- ☐ Records of office visits performed at this facility (including history & physical)
- ☐ Hospital H&P and/or Discharge Summary (if done by our physician)
- ☐ Test/Lab Results
- ☐ Referrals to other physicians
- ☐ All Records
- ☐ Medication List **Date from** _____
- ☐ Treatment Plan **to** _____
- ☐ X-ray Reports
- ☐ Insurance information
- ☐ Other _____

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.

METHOD OF RECORD RELEASE:

- ☐ Paper copy via mail: (mailing address)_____
- ☐ Paper copy to be picked up in person
- ☐ Encrypted electronic copy via email: (Email address) _____
- ☐ Other: (Describe) _____

FOR THE PURPOSE OF: (Describe) _____

REVOCATION AND EXPIRATION:

This authorization may be revoked at any time by my written consent except to the extent that action has already been taken in reliance thereon. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Privacy Officer (225 E. Jackson St., Jonesboro, AR 72401, (870) 207-2422). I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. 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 6 months.

FAILURE TO SIGN AUTHORIZATION:

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in DFR 164.524. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions of my health information, I can contact the Privacy Officer at the above address and telephone number.

St. Bernards Clopton Clinic may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization. Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected under federal privacy law.

_____ _____
Signature of Patient of Personal Representative Date/Time

_____ _____
If signed by Personal Representative, Relationship to Patient Signature of Witness

05/2017