St. Bernards OB-GYN ASSOCIATES
The Heart of Great Medicine
800 South Church St., Suite 302 • Jonesboro, AR 72401 • Phone: 870-935-3990 • Fax: 870-935-0871

AUTHORIZATION TO RELEASE HEALTH INFORMATION

NAME: _____ **SSN#:** _____ **DOB:** _____

ADDRESS: _____

Pursuant to Federal Guidelines concerning my right to confidentiality

1. PARTY TO RECEIVE INFORMATION:

I hereby authorize: _____
Entity, person(s), or class of persons

To release to: _____
Entity, person(s), or class of persons

2. TYPES OF INFORMATION:

The type and amount of information to be used or disclosed is as follows:

□ Entire medical record for _____
Date(s) of service

OR

□ History/physical
□ Discharge summary
□ Consultation report
□ Operative report
□ Physician's orders
□ Progress notes
□ Nurses notes
□ Medication records
□ Laboratory results
□ X−ray results
□ Itemized statement
□ Other (Please specify)
_____
_____

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.

3. 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 above

4. FOR THE PURPOSE OF: _____
Describe above

5. 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 Street, Jonesboro, AR 72401; (870) 207.4422). 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.

6. 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 CFR 164.524. I understand that any disclosure of information carries with it 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.

7. St. Bernards OB-GYN Associates may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization.

8. 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 or Personal Representative — Date/Time

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