Parkhill

The Clinic for Women

Authorization To Release Medical Records

Patient Full Name: ______________________ **Date of Birth:** __________

Patient Street Address: ______________________

Patient City, State, Zip: ______________________

Patient Telephone: ______________________

I hereby authorize the release and disclosure of the following specific medical information. I understand there may be fees, based on volume, associated with the reproduction of the requested medical records. My authorization extends only to those data elements/documents initialed below:

Initial any or all that apply:

_____ Statements of charges or payments
_____ Records of *all* visits
_____ Record of visit for a specific date or dates. Specific dates include or are limited to: ______________________
_____ Copies of records or reports provided to the above named (i.e., hospital, lab, clinic etc.)
_____ Progress Notes
_____ Discharge Summary
_____ History and Physical Examination
_____ Consultation Reports
_____ *All of the above*
_____ Other (Must be specific) ______________________
_____ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Information
_____ Hepatitis Information

These records are released for the purpose of: ______________________

Release Records:

___ **To** ___ **From**

Parkhill Clinic for Women
PO Box 8850
Fayetteville, AR 72703

Telephone: 479.521.4433
Facsimile: 479.521-0444

___ **To** ___ **From** ___ **Patient will Pickup**

Name: ______________________
Address: ______________________
City, State, Zip: ______________________

Telephone: ______________________
Facsimile: ______________________

This authorization is given freely with the understanding that: **1.** Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law. 2. A photocopy or fax of this authorization is as valid as this original. 3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available from the receptionist. 4. Parkhill Clinic for Women, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. 5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this Authorization. 6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

______________________ **Patient's Printed Name**

______________________ **Date**

______________________ **Patient's Signature**

______________________ **Expiration Date** (If other than one year from date above)

______________________ **Social Security Number** (For identification purposes only)

______________________ **Patient's Personal Representative**

______________________ **Date**

______________________ **Patient's Personal Representative's Authority to Act**

______________________ **Witness**

Form ARMR 9/7/06