Parkhill
the clinic for women

Authorization To Release Medical Records

Patient Full Name : _____ Date of Birth:_____

Patient Street Address:_____

Patient City, State, Zip Code:_____

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 dates elements/documents initialed below:

____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 (Aquired Immunodeficiency Syndrome) or HIV Information
____Hepatitis Information

These records are released for the purpose of: _____

RELEASE RECORDS

____TO ____FROM ____TO ____FROM ____Patient will pickup

Parkhill Clinic for Women
PO BOX 8850
Fayetteville, AR
Telephone: 479-521-4433
Facsimile: 479-521-0444
Email: mrecords@parkhillclinic.com
info@parkhillclinic.com

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**

_____
Social Security Number

_____ _____
Patient's Personal Representative **Date**

_____ _____
Patient' Personal Representative Authority to Act **Witness**