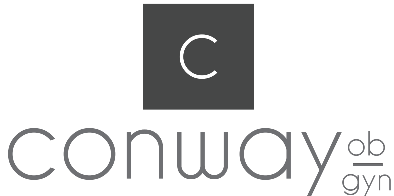

Conway Obstetrics & Gynecology Clinic, P.A.
Conway, Arkansas 72034

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I hereby give my authorization for Conway OB/GYN Clinic, P.A. to use or disclose my protected health information to carry out treatment, payment, or any other health care operations.

I understand that my protected health information is as follows:

Information that is oral or recorded in any form that relates to my past, present, or future health care treatment; or the payment of my past, present, or future health care treatment, that is or could reasonably identify me and is transmitted in an electronic form or maintained in any form.

This protected health information could include information that this health care provider created, received from me, received from another health care provider, received from a health plan, health care clearing house, insurance company, employer, or any other source, and could include demographic information about me.

I specifically give this health care provider authorization to disclose my protected health information to the following persons for the following purposes:

☐ Surgery Results ☐ Appointments ☐ Account Information

☐ Prescriptions and Refills ☐ Any and all Protected Health Information

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

I understand that I have the right to revoke my authorization; however, it shall not be considered revoked to the extent my health care provider has relied on it. I understand that once this information has been disclosed to third parties, there may not be any safeguards to prevent the third party from further disclosing the protected health information.

☐ I request this authorization never expire.

☐ I request this authorization expire on the following date:______________.
I understand that I must deliver a written revocation to Conway OB/GYN Clinic at 2519 College Ave., Conway, AR 72034.

Patient - Printed Name: ______________________ Date: ______________

Personal Representative of Patient: ______________________

Patient - Signature : X______________________