Arkansas Methodist Medical Center
Authorization for Access by Patient or Disclosure of Protected Health Information

Patient Name: _____ Medical Record #: _____

Date of Birth: _____ Social Security #: _____

I hereby authorize the use of disclosure of the Protected Health Information described below to be provided to or obtained by the following:

Name of Individual/Facility/Company to receive PHI

_____
Name

_____
Address

Name of Individual/Facility to Disclose PHI

Arkansas Methodist Medical Center
900 W. Kingshighway
Paragould, AR 72450

Information Authorized for use or disclosure or to be obtained:

☐ Medical Information concerning this patient.
☐ Medical Information for this patient compiled between _____ and _____
☐ Only: _____
Dates of treatment (if known): _____

The information will be obtained, used or disclosed for the following purpose(s) only:

☐ Insurance
☐ Continued Treatment
☐ Legal
☐ At the request of the patient

I understand: I may revoke this authorization at any time, in writing, except revocation will not apply to information already used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Practices. Unless revoked or otherwise indicated, the automatic expiration date will be one year from the date of signature or upon occurrence of the following event: _____

- I release the entities listed above, their agents and employees from any liability in connection with the use of disclosure of the Protected Health Information covered by this authorization. This entity authorized to disclose the information will not be compensated by the recipient for the disclosure, except for the cost of copying and mailing as authorized by law.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- I have the right to inspect the health information to be released and I may refuse to sign this authorization.
- Unless the purpose of the authorization is to determine payment of a claim of benefits, the requesting entity will not condition the provision of treatment for my care on my signing of this authorization.

I understand that my medical information may indicate that I have a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea or the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have been treated for psychological or psychiatric conditions or substance abuse.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Description of Legal Representative's Authority Expiration Date of Authorization

NOTICE OF RIGHTS: Information in your medical records that you have may or may not have had communicable disease is made confidential by law and cannot be disclosed without your written permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court of the Department of Health, disclosure among health care providers or disclosure for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court or the Heath Department or by law.