Family Practice Associates

1304 Military Road, Benton, Arkansas 72015
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Patient Authorization for Use and Disclosure of Protected Health Information

PLEASE PRINT CLEARLY

1. Who needs your records? Choose one of the 3 options below.

❑ I am requesting that the following doctor/organization release my medical record to Family Practice Associates: *{This means you need outside records added to your chart in our office.}*

❑ I am requesting that Family Practice Associates send my medical record to the following doctor/organization: *{This means you want our clinic to send your records to another provider.}*

Doctor/Organization: _____ Phone: _____ Fax:_____

Address: _____
Street Address City State Zip

❑ I am requesting that Family Practice Associates release my medical record to me on a CD.

The cost for my record will be $15. My CD should be: ○mailed to me **or** ○I will come pick up

Records released to the patient will be mailed or ready for pick-up within 10 business days.
Only records that are paid for at the time of the request can be mailed.

2. What information needs to be released?

○ Entire medical record ○ Most recent office visit note

○ Last ___ years of records ○ Most recent lab work

○ Other: (please be specific)_____

3. Patient Information

Name: _____ DOB: _____ SSN: _____ Phone: _____

Address: _____
Street Address City State Zip

Information to be Used or Disclosed for the Following Purpose: At the request of the patient
This authorization will expire once specified information above is sent/received or in 6 months.

By signing this form, I authorize those listed above to use or disclose the protected information specified above about me. I do not have to sign this authorization in order to receive treatment from Family Practice Associates. I have the right to refuse to sign this authorization. When my information is released pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be sent to the Privacy Officer at 1304 Military Rd, Benton, AR 72015.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Printed Patient Name Patient Date of Birth

_____ _____
Printed Name of Legal Guardian Relationship to Patient