Conway Women's Health Center
AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is used to authorize the release of Protected Health Information ("PHI") in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may make this authorization invalid.

I specifically give Conway Women's Health Center ("CWHC") authorization to use or disclose my PHI to the following person(s) for the following purpose(s):

Please Transfer Records To:
Conway Women's Health Center
2200 Ada, Suite 301
Conway, AR 72034
(501) 450-3920
(501) 450-7718 fax

Please Transfer Records From:
Name: _____
Address: _____
_____
_____
Phone: _____
Fax: _____

Records to be Released:
☐ Entire Record – Date(s) of Service:_____
☐ Lab Test(s) – Date(s) of Service: _____
_____
☐ Other (Please specify needed Information & Date(s) of Service(s) known): _____
_____
_____
_____

Purpose(s):
The purpose of this release of PHI is:
☐ Continuation of Medical Care
☐ Transferring Medical Care
☐ Physician Record Review
☐ Other (Specify): _____
_____

☐ I specifically authorize CWHC to release any sensitive information contained in my PHI regarding: AIDS/HIV test results, abuse and/or addiction treatment notes, psychotherapy notes. Restrictions to this specific authorization:_____
_____

I understand that I have the right to revoke my authorization; however, it shall not be considered revoked to the extent CWHC 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 understand the Health Care Provider cannot condition my treatment or evaluation on my signing this authorization.

_____ _____ _____
Patient – Signature (if age 18 or older) Printed Name Date of Birth

_____ _____
Parent/Guardian of Patient Today's Date

☐ I request that this authorization never expire.
☐ I request that this authorization expire _____.

I may revoke my authorization sooner in writing by contacting the Privacy Official, Katy Mullins.
I may also reach her by phone at 450-3920.

If records exceed over 20 pages, please mail.

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☐ Other (Please specify needed Information & Date(s) of Service(s) known): _____
_____
_____
_____

Purpose(s):
The purpose of this release of PHI is:
☐ Continuation of Medical Care
☐ Transferring Medical Care
☐ Insurance or Third Party Reimbursement
☐ Other (Specify): _____
_____

☐ I specifically authorize CWHC to release any sensitive information contained in my PHI regarding: AIDS/HIV test results, abuse and/or addiction treatment notes, psychotherapy notes. Restrictions to this specific authorization:_____
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