CENTRAL CLINIC FOR WOMEN
9601 BAPTIST HEALTH DRIVE, SUITE 500
LITTLE ROCK, AR 72205
PHONE NUMBER (501)227-5885
FAX NUMBER (501)227-5005

# PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

**By signing this authorization, I authorize Central Clinic for Women, P.A. to use and/or disclosed certain protected health information (PHI) about me to or for the party or parties listed below.**

**This authorization permits Central Clinic for Women, P.A. to use or disclose to**

_____, _____
**Person or Entity to Receive the Information** **Address**

**the following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.).**

_____
_____
_____

**This authorization will expire on** _____.
**{Expiration Date or Defined Event}**

**When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may be 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 Central Clinic for Women, P.A. has acted in reliance upon this authorization. My written revocation must be submitted to Central Clinic for Women, P.A.'s Privacy Officer at 9601 Lile Drive, Suite 500, Little Rock, AR. 72205**

**Signed by:** _____ _____
**Signature of Patient or Legal Guardian** **Relationship to Patient**

_____ _____
**Print name of Patient or Legal Guardian** **Date**

**Patient's Date of Birth**_____
**Patient's Soc. Sec. #**_____