Lifespring
women's healthcare

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RECEIVE INFORMATION:

RELEASE INFORMATION: Name/Address, Phone# and FAX #

Patient identification

Printed Name:_____ Date of Birth:_____

Address:_____

Social Security #:_____ Telephone: _____

Information to be released – Covering the periods of Health Care

From (date) _____ to (date)_____

From (date) _____ to (date)_____

Please check type of information to be released:

☐ Entire medical record	☐ Pathology report	☐ Discharge summary
☐ History and physical exam	☐ Consultation reports	☐ Progress notes
☐ Laboratory test results/reports	☐ X-ray reports	☐ X-ray films/images
☐ Operative report	☐ Emergency room record	☐ Itemized bill

☐ Other, (specify) _____

Purpose for Request

☐ Treatment or consultation ☐ At the request of the patient ☐ Billing or claims payment

☐ Other, (specify)_____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexuality transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release.

Check One: ☐YES ☐NO _____Initials

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Humans Immunodeficiency Virus/Acquired immunodeficiency Syndrome) testing, and/or treatment, I agree to its release.

Check One: ☐YES ☐NO _____Initials

Time Limit & Right to Revoke Authorization

This authorization is good for 180 days from time of signature. Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at 609 W. Maple Ave., Springdale, AR 72764

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient Representative Who May Request Disclosure

I understand that Lifespring Women's Healthcare may not condition my treatment on whether I sign this authorization form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. I authorize the above named to use and disclose the protected health information specified above.

Signature:_____ **Date:**_____

Authority to sign if not patient:_____

Identity of Request Verified via: ☐**Photo ID** ☐**Matching Signature** ☐**Other, specify** _____

Verified by:_____