HOWARD MEMORIAL HOSPITAL

130 MEDICAL CIRCLE

NASHVILLE, ARKANSAS 71852

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name (print): _____

Patient Address (print):_____

Social Security Number: _____ **Date of Birth:**_____

By signing this Authorization Form, I understand that I am giving my authorization to Howard Memorial Hospital's designated medical record custodians to use and/or disclose my protected health information (PHI), as described in more detail in the paragraphs below, to the following person(s) or organization(s):

Name of person(s) or organizations(s):_____

Street Address: _____

City, State, and zip code: _____

Telephone number: _____Facsimile number:_____

For additional organizations, see attachment.

Number of additional organizations (must be answered to be valid)_____

I specifically authorize the use and disclosure of the following PHI:

(Please provide a detailed description of the particular data and period of time you are requesting)

____ Emergency Records_____

_____

____ Hospital/Inpatient Records_____

_____

_____ Clinic/Outpatient Records_____

_____

_____ Laboratory Reports_____

_____

_____ Pathology Reports_____

_____

_____ Radiology Reports_____

_____

If this authorization is for any purpose other than the release of medical records for personal reasons, please state the

purpose of the authorization to release PHI below:

_____

The information to be used or disclosed pursuant to this authorization form may include information relating to: (1) Acquired immunodeficiency syndrome ("AIDS") or human immunodeficiency virus ("HIV') infection; (2) treatment for drug or alcohol abuse; or (3) mental or behavioral health or psychiatric care. If you are requesting psychotherapy session notes maintained by a mental health provider, a separate authorization form must be completed when requesting psychotherapy session notes and records.

I may revoke this authorization at any time by notifying the facility in writing to the Health Information Management Department, (insert address of facility) of my intent to revoke this authorization. However, I also understand that such a revocation will not have any effect on any information already used or disclosed by the facility before the facility received my written notice of revocation.

Unless earlier revoked, this authorization will expire on the 60th day of the signing or as otherwise specified below:

_____

If neither federal nor state privacy laws apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or state privacy law.

I may inspect and receive a copy (state law establishes reasonable fees for copy charges of medical records) of the information to be used and disclosed pursuant to this Authorization form.

This Authorization is voluntary and I may refuse to sign this Authorization form.

If I am providing authorization for marketing purposes, I understand that facility may receive remuneration from a properly authorized business associate as a result of using or disclosing the patient's PHI.

I understand that I am not required to sign this authorization form in exchange for the patient receiving treatment from facility.

_____ _____

Signature of patient or personal representative Date

_____ _____Picture ID obtained

Printed name of patient

_____ _____

Printed name of personal representative (if applicable) Witness

_____

Relationship to the patient giving representative authority to act for patient (if applicable)