Siloam Springs Women's Center

603-2 N. Progress Ave, Suite 100 • Siloam Springs, Arkansas 72761
Phone 479-524-9312 • Fax: 479-524-9627

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the release of my medical information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider subject to federal or state regulations, the released information may no longer be protected by federal or state privacy regulations.

Patient's name:_____ **Birth date:** _____

I authorize SSWC to (check one) [ ] release information to or [ ] obtain information from:

Name of Facility or Person: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: _____ **Fax Number:** _____

Portion of the medical record to be released: Specify dates of service: _____
[ ] Copy of complete record [ ] Radiology/Ultrasound Reports [ ] Laboratory Reports
[ ] Other _____

Portion of the medical record, if any, not to be released: _____

What is the purpose of the requested release?: _____

I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, enrollment in any health plan, or eligibility of benefits unless allowed by law. I understand that I have the right to request a copy of this form after I sign it.

I understand that if my medical record contains information which indicates the presence of a communicable or venereal disease, including, but not limited to, hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS), as well as mental health information, and/or records concerning treatment for alcohol and/or drug abuse, I agree to its release.

Authorization will expire in ninety (90) days, or (specify date or event):_____

I hereby affirm that I have read and fully understand the provisions of this form and consent to the disclosure of medical records for the purposes stated above. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any effect on any actions taken before receiving the revocation.

_____ _____
Signature of patient/patient's representative/agent *(Form MUST be completed before signing)* **Date of Signature**

_____ _____
Printed name of patient's representative or agent **Relationship to the patient**

SSWC USE ONLY: ID of Requestor Verified [ ] Photo ID; [ ] Matching signature; [ ] Other: _____	
Information *released* [ ] mailed, [ ] given to patient, [ ] faxed or [ ] other _____ # of pages copied: _____ Fee for copies _____	Information *requested*: Authorization [ ] mailed, [ ] faxed, or [ ] other _____
Request processed by: _____ Date: _____	

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