

ARKANSAS UROLOGY, P.A.
1300 CENTERVIEW DRIVE
LITTLE ROCK, AR 72211

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I authorize the use/disclosure of my health information as described below:

1. Who is authorized to use/disclose the information: _____

2. Who is authorized to receive the information: _____

3. Description of information that may be used/disclosed; and the dates of such Information (for example, nurses notes from 01-01-01 to 01-01-01): _____

4. The information will be used/disclosed for the following purposes: _____

5. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

6. I understand that Arkansas Urology, P.A. will be paid for the costs of copying the information to be released.

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information used/disclosed under the authorization.

8. I understand that I may revoke this authorization in writing at any time by delivering a copy of my revocation to Arkansas Urology, P.A. except to the extent that action has been taken in reliance on this authorization. This authorization expires ninety (90) days from the date it is signed below.

Signature of Patient or Representative

Date

Patient's Name

Date of Birth

Name of Personal Representative (if applicable)

Relationship to patient

Witness

Date