

**PATIENT AUTHORIZATION FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

PATIENT NAME: _____ PHONE # _____

Patient S.S.#: _____ Date of Birth: _____

By signing this authorization, I authorize Arkansas Otolaryngology Center PA and AOC Surgery Center Inc to use and/or disclose certain protected health information (PHI) about me to:

Name: _____
Name of entity to receive this information Complete Address Relationship?

Name: _____
Name of entity to receive this information Complete Address Relationship?

Name: _____
Name of entity to receive this information Complete Address Relationship?

This authorization permits Arkansas Otolaryngology Center PA and AOC Surgery Center Inc to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

Audio Report Complete Records Other (specify) _____

Authorization to discuss (oral communication) and/or provide written communication or records regarding ANY & ALL of my PHI, including account information & medical care issues, with the above-named party(ies), in regards to my medical care, prognosis, diagnosis and/or my account information.

The information will be used or disclosed for the following purpose:

At the request of the individual
 Other _____

This authorization will expire on: _____ . If I fail to specify an expiration date, this authorization will expire in **THIRTY DAYS** from date of signature..
{Expiration Date or Defined Event}

Based on Arkansas state law, our practice may charge for copying charges, including the cost of supplies and labor, and postage related to the production of my information. I understand and agree that if copying charges are required, I am financially responsible for the following fees associated with my request. \$1.00 per page for the first 5 pages, and \$.25 for each additional page, with a minimum charge of \$5.00.

I do not have to sign this authorization in order to receive treatment from Arkansas Otolaryngology Center or AOC Surgery Center Inc. In fact, I have the right to refuse to sign this authorization.

I further understand this authorization allows release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may 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 the practice has acted in reliance upon this authorization. My written revocation must be submitted to:

**Privacy Officer
Arkansas Otolaryngology Center
10201 Kanis Road
Little Rock, AR 72205**

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

Print Name of Patient or Legal Guardian Date