REQUEST BY AOC TO OBTAIN MEDICAL RECORDS (PHI) **AOC ACCT # _____**

H.I.P.A.A. – Compliant

PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

X PATIENT NAME: _____

PHONE # _____ DATE OF BIRTH: _____

Patient S.S.#:_____

X By signing this authorization, I authorize _____to disclose certain protected health information (PHI) about me TO**:**

Arkansas Otolaryngology Center, PA/AOC Surgery Center, Inc. / Dr. _____

[ ] 10201 Kanis Road **Little Rock, AR 72205** **Phone: 501-227-5050** **FAX: 501-227-5151**	**[ ] 500 S. University, #423** **Little Rock, AR 72205** **Phone: 501-664-4381** **Fax: 501-661-1228**	**[ ] 4901 Fairway, Ste C** **N. Little Rock, AR 72116** **Phone: 501-753-8444** **Fax: 501-753-9170**	**[ ] 2305 Springhill Road, # 8** **Benton, AR 72019** **Phone: 501-943-3214** **Fax: 501-943-3219**	**[ ] 1715 W. Main St.** **Heber Springs, AR 72543** **Phone: 501-362-0606** **Fax: 501-362-8842**

This authorization permits the above-named holder of protected health information (PHI) to 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.):

X []Complete Records (including oral communication as needed to facilitate treatment)
[]Other (specify)_____

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

X [] For the medical records of Arkansas Otolaryngology Center, PA/AOC Surgery Center, Inc
[] At the request of the individual
[] Other_____

X This authorization will expire on: _____. If no expiration date is given, this
{**Expiration** Date or Defined Event}.
authorization will expire in 30 days.

- I do not have to sign this authorization in order to receive treatment. 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 the Privacy Officer at the above-named holder of PHI's place of business.

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

_____ _____
Print Name of Patient or Legal Guardian Date

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION