White Hall Family Medicine Associates

Patient Authorization for Use and Disclosure
of Protected Health Information

Date of request:_____

By signing this authorization, I authorize White Hall Family Medicine Associates to use and/or disclose certain proctected health information (PHI) about me:

TO or FROM (choose one):
Name:_____
You must list the person(s) needing the information & where the information needs to go.

Address:_____

_____

Phone:_____ Fax:_____

Authorization permits White Hall Family Medicine Associates to use and/or disclose the following individually identifiable health information about me. **Specifically describe the information to be used or disclosed, such as dates of service, type of service level and detail to be released or origin of information.**

☐ **All Medical Records_____** ☐ **Lab Only_____**

☐ **X-Ray Only _____** ☐ **Office Notes_____**

☐ **Procedure _____** ☐ **Other:_____**

_____

This information will be used or disclosed for the following

purpose:_____

If requested by the Patient, purpose can be listed as "at the request of the individual".
The purpose(s) is so that I can make an informed decision whether to allow release of the information.

This authorization will expire on:_____(6 months from date signed).

I understand I have the right to refuse to sign this authorization. I understand that WHFM will not condition treatment, payment of healthcare services enrollment of eligibility for health care benefits on signing this Authorization. A photocopy of this Authorization is as valid as the original. 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. WHFM, its employees and physicians are released from legal responsibility or liability for the release of the information to the extent indicated and authorized here in. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. I understand this Authorization is only good for six months from the date signed. My written revocation must be submitted to the Privacy Office at WFHM, 1400 Claud Rd, White Hall, AR 71602.

Patients Name (Print):_____D.O.B._____

Signed by:_____Relation to Patient:_____
(Signature of Patient or Legal Guardian)

Printed Name of Legal Guardian:_____
(If signing for the Patient)

Date:_____