

HEART CLINIC ARKANSAS
10100 Kanis Road
Little Rock, AR 72205

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 01-15-01): _____

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 Heart Clinic Arkansas may 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 or my eligibility for benefits. I may inspect or obtain a copy of any information used/disclosed under this authorization.

8. I understand that I may revoke this authorization in writing at any time by delivering a copy of my revocation to Heart Clinic Arkansas 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 Printed Name

Patient's Date of Birth

Patient's SSN

Name of Personal Representative (if applicable)

Relationship to Patient

Witness

Date