BRYANT FAMILY CLINIC, P.A.

A Member of Arkansas Family Care Network

AUTHORIZATION TO RELEASE AND/OR RECEIVE RECORDS

PATIENT NAME: _____

DOB: _____ SSN: _____ PHONE # _____

ADDRESS: _____

I hereby authorize BRYANT FAMILY CLINIC to:

◯ Release copies of billing or medical record to the following persons or entities.

◯ Receive copies of billing or medical records from the following persons or entities.

_____

_____

The following information shall be obtained and/or release pursuant to the authorization:

◯ History and Physical	◯ Operative Report
◯ Pathology Report	◯ Radiology Report
◯ Billing Records	◯ Other (specify)
◯ Entire Designated Record Set	_____

Information may be released in writing, verbally, or by video, fax, photocopy or microfilm

I request that the above information be released for the following dates of service:

_____

NOTICE TO THE PATIENT/PATIENT REPRESENTATIVE: If the recipient of the information disclosed pursuant to this Authorization is not a health care provider, health plan or healthcare clearinghouse, the information may be subject to disclosure by the recipient and may no longer be protected by federal privacy laws and regulations.

This authorization will expire one year from the date of the signature below.

The information will be obtained and/or disclosed for the following reason(s):

◯ Treatment/ Continuity of Treatment	◯ Legal Reasons
◯ AT THE REQUEST OF THE INDIVIDUAL	◯ Assessment and Evaluation
◯ Other (specify) _____	

This authorization may be revoked by notifying our Privacy Officer in writing at the following address:

Jeff Erwin, AFCN Privacy Officer, Bryant Family Clinic, 507 W. Commerce, Bryant Ar., 72022

Phone: 501- 847-0082 Fax: 888 398 1004

NOTE: Protected health information may already have been disclosed before the revocation is received. If so the revocation will be effective only as of the date it is received by AFCN.

Patient signature: Date:

_____

If patient representative what is relationship or authority?

_____

This authorization is voluntary. A refusal to sign will not affect the patient's ability to obtain treatment, payment or, if applicable enrollment in a health plan or eligibility for benefits.