AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient name: _____ Date of birth: _____ SS#: _____

Address:_____ Phone: _____

I authorize **Fayetteville Surgical Associates** 3264 N. Northhills Blvd. Fayetteville, AR 72703

PHONE: 479-521-3300 FAX: 479-521-4705

Disclose information to: _____
_____
_____

The type of information to be used or disclosed is as follows (check the appropriate line(s) and include other information where indicated): Date(s) of service: _____

_____ Progress Notes _____ Diagnostic Test Reports (lab, radiology, etc.)
_____ Procedure Reports_____ Radiology Disc (Please circle): X-RAY MRI ALL
_____ Entire Record _____ Other _____

This information for which I am authorizing disclosure will be used for the following purpose(s):

_____My personal records _____Legal purposes _____Continuing medical care
_____Social Security/Disability _____Insurance _____Other
_____At the request of the Individual

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the staff of Fayetteville Surgical Associates. I understand the revocation will not apply to information that has already released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless I specify differently, this authorization will expire within 12 months from the date on which it was signed. I understand that once the above information is disclosed it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

I do not have to sign this authorization in order to receive treatment from Fayetteville Surgical Associates. In fact, I have the right to refuse to sign this authorization.

_____ _____
Signature of Patient or Legal Representative Date

_____
Relationship to Patient