Conway Women's Health Center

PATIENT SPECIFIC AUTHORIZATION FOR PHI ACCESS & COMMUNICATION

I hereby give specific authorization for Conway Women's Health Center ("CWHC") to use or disclose my Protected Health Information ("PHI") in the manner designated below for communicating with me directly with my PHI.

This PHI could include information that CWHC created, received from me, received from another Health Care Provider, received from a Health Plan, Health Care Clearing House, Insurance Company, Employer, or any other source, and could include demographic information about me.

I specifically give CWHC authorization to contact me &/or leave messages for me in any of the following ways:

☐ Home phone number: ____________________________ ☐ Cell phone number: ____________________________

☐ Other phone number: ____________________________ ☐ Text Message number: ____________________________
(Appointment Reminders only)

☐ No, I do not want to be left messages containing any of my Protected Health Information

If you are a Secure Patient Portal account holder, CWHC will designate your preferred communication as Patient Portal unless you designate in writing otherwise: ☐ No, I prefer to be contacted by: ____________________________

CWHC utilizes SureScipts for electronically prescribing medications. This system uses pharmacy benefit managers (PBMs) and payers to offer prescribers access to their patients' prescription benefit information in real time during an office visit. The Prescription Benefit service puts eligibility, benefits & formulary information at the prescriber's fingertips at the time of prescribing. We will designate this functionality unless you refuse this service in writing otherwise: ☐ No, I prefer CWHC not utilize this functionality to obtain my pharmacy benefits & information.

Please allow the following person(s) to have access to my Protected Health Information Listed:

____________________________(name)
____________________________(address)
____________________________(city,state,zip)
____________________________(phone)
____________________________(relationship)

Restrictions to Protected Health Information:

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I understand that I have the right to revoke my authorization. I understand that once my information has been disclosed to third parties, there may not be any safeguards to prevent the third party from further disclosing the Protected Health Information.

____ ____
Patient – Printed Name Patient – Signature (if age 18 or older)

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Patient's Date of Birth

_______________________ ____________________________
Parent/Guardian of Patient Today's Date

☐ I request that this authorization never expire.
☐ I request that this authorization expire ________________________.

I may revoke my authorization sooner in writing by contacting the Privacy Official, Katy Mullins.
I may also reach her by phone at 450-3920.