Carriage Hill Family Care, PLC
3501 Carriage Hill Dr Ste B | Paragould, AR 72450 | P: (870) 573-2200 | F: (870) 573-2300

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

REQUEST RECORDS TO CHFC - COMPLETE ALL SECTIONS, DATE, AND SIGN

I. PATIENT AUTHORIZATION

I, _____, authorize the disclosure of information from my medical record.

Birthdate: _____ SSN (last 4 digits): XXX-XX-_____

Phone: _____ Address, City, State, Zip: _____

Email: _____

II. RELEASING AND RECEIVING INFORMATION

THE INFORMATION IS TO BE DISCLOSED BY:

Name of facility / person: _____

Address, City, State, ZIP: _____

Phone: _____ Fax: _____

THE INFORMATION IS TO BE PROVIDED / SENT TO:

Carriage Hill Family Care, PLC
3501 Carriage Hill Dr Ste B, Paragould, AR 72450
Phone: (870) 573-2200 Fax: (870) 573-2300

III. PURPOSE OR NEED FOR THIS DISCLOSURE

☐ Continued treatment ☐ Personal use ☐ Attorney ☐ Insurance ☐ School ☐ Disability ☐ Research ☐ Other: _____

IV. INFORMATION TO BE DISCLOSED FROM MY MEDICAL RECORD (CHECK APPROPRIATE BOX/ES)

☐ Only information related to (specify): _____
☐ Only for dates of service from _____ to _____
☐ Other (specify; e.g., radiology, laboratory, billing): _____
☐ Entire record

V. IF YOU WOULD LIKE ANY OF THE FOLLOWING SENSITIVE INFORMATION DISCLOSED, CHECK THE APPLICABLE BOX/ES BELOW

☐ Substance Use Disorder (SUD) Diagnosis/Treatment/Referral
☐ Mental Health (Other than Psychotherapy Notes)
☐ Sexually Transmitted Diseases
☐ Genetic Testing
☐ HIV/AIDS Testing & Treatment
☐ Sexual & Reproductive Health

Psychotherapy notes and separately maintained SUD counseling notes require a separate authorization/consent when applicable.

Preferred delivery (optional): ☐ Fax ☐ CD ☐ Mail/paper ☐ Secure electronic ☐ Other: _____

VI. VOLUNTARY AUTHORIZATION / NON-CONDITIONING

I understand that by signing this authorization, my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

VII. REDISCLOSURE

I understand that information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA. Other federal or state confidentiality protections may continue to apply.

VIII. REVOCATION

I may revoke this authorization by notifying the facility/person identified above as releasing the information in writing of my desire to revoke it. However, I understand that actions already taken based on this authorization cannot be reversed and my revocation will not affect those actions.

IX. EXPIRATION

This authorization expires on _____, 20____, OR upon the following event: _____

If no date or event is specified, this authorization will automatically expire one (1) year from the signature date.

SIGNATURE OF PATIENT: _____ **DATE:** _____

SIGNATURE OF PERSONAL REPRESENTATIVE & RELATIONSHIP/AUTHORITY TO ACT FOR PATIENT:

_____ DATE: _____

SIGNATURE OF WITNESS (if signature of patient is a thumbprint or mark):

_____ DATE: _____

A photocopy, faxed copy, or electronic copy of this signed authorization may be relied upon as if it were the original.