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

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name: _____ Date of Birth:_____

Phone Number_____ Last Four Digits of Social Security Number:_____

Address_____

Email Adress_____

Authorization

I hereby authorize: _____
Entity, person(s), or class of persons

To disclose my protected health information to:

Carriage Hill Family Care, PLC and its medical providers, employees and agents

Information to be Released

Date(s) of Service Requested: _____

☐ Entire medical record (including psychotherapy notes if applicable)

☐ Other (specify): _____

I understand that this information may include records related to mental health, communicable diseases, HIV/AIDS, and alcohol or drug use.

Purpose of Disclosure

☐ Continuity of care ☐ Personal use ☐ Insurance ☐ Legal

☐ Other: _____

Format of Records

☐ Paper ☐ CD ☐ Encrypted email ☐ Unencrypted email (not secure)

I understand that choosing unencrypted email carries risks, including unauthorized access or disclosure.

Right to Revoke

I understand that I have the right to revoke this authorization at any time by submitting a written request to Carriage Hill Family Care, PLC. I understand that the revocation will not apply to information that has already been released in reliance on this authorization.

Redisclosure

I understand that information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations.

_____ _____

Patient Signature Date

_____ _____

Legal Representative, if not patient Date