RICE CLINIC

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Complete all Sections, Date and Sign

I. I, _____ hereby voluntarily authorize and request:

Rice Clinic
1301 Wilson Road
Little Rock, AR 72205
Phone: (501) 225-0576 Fax: (501) 225-6789

_____To release copies of my medical records to: _____To obtain copies of my medical records from:

Name of person or agency: _____ Phone number: _____

Address: _____ Fax Number: _____

_____ Dates of Service: _____

II. The purpose(s) or need for this disclosure is:

☐ Further medical care ☐ Attorney ☐ School/Work ☐ Research ☐ Insurance Use

☐ Personal Use ☐ Disability ☐ Other: _____

III. The information to be disclosed from my health record (*check appropriate box(es)*

☐ Initial Evaluation	☐ Emergency Record(s)	☐ Other:
☐ Progress Notes	☐ Laboratory Test(s)	
☐ Complete Medical Record		

Period of time of event(s) from _____ to _____.

If you would like any of the following sensitive information disclosed, initial the space next to the source.

_____ HIV/AIDS Related Treatment/Tests _____ Psychotherapy Notes _____ Genetic Testing

_____ Alcohol/Drug Abuse Treatment/Referral _____ Sexually Transmitted Diseases

IV. **Expiration:** This authorization shall become effective immediately and shall remain in effect until (enter specific date) _____. If no date is given, the authorization shall be valid for one year from the date of signing.

V. **Rights:** I understand: I have the right to revoke this Authorization by written request at any time; my revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my Authorization was valid; my records may be subject to re-disclosure by recipient(s) and unprotected by Federal or State law; I may inspect a copy of my Protected Health Information to be used or disclosed under this Authorization; I may refuse to sign this Authorization and my refusal will not affect my eligibility for care or condition treatment; and a copy of this signed, dated Authorization shall be effective as the original.

PATIENT IDENTIFICATION: NAME		SOCIAL SECURITY NUMBER
ADDRESS		
CITY/STATE/ZIP	PHONE NUMBER	DATE OF BIRTH

SIGNATUE OF PATIENT OR PERSONAL REPRESENTATIVE	DATE
Relationship to Patient	