BOSTON MOUNTAIN RURAL HEALTH CENTER, INC.

Authorization to Release Protected Health Information

Patient Information: *(Please complete Name, DOB, and SSN information in section below.)*			
Full Name:		**Date of Birth:**	
SSN:		**Account No.:**	

1. I authorize the release of the above named individual's medical records as directed below:
2. I authorize the entity indicated in the "Release Information From" section to make disclosure to the entity indicated in the "Release Information To" section below:

Release Information From:	**Release Information To:**
☐ Boston Mountain Rural Health Center, Inc. Box 1030, Marshall, AR 72650 ☐ Other:_____ _____ _____	☐ Boston Mountain Rural Health Center, Inc. PO BOX 1030, Marshall, AR 72650 Phone 870.448.5733 Fax:877.553.0085 ☐ Other:_____ _____ _____

3. The type of information to be disclosed is as follows:

Dates of Service (optional): To: From:
☐ **Clinic Notes** ☐ **Laboratory Reports** ☐ **Radiology Reports** ☐ **Radiology Images** ☐ **Pathology Reports** ☐ **EKG** ☐ **Billing Information** ☐ **Behavioral Health Visit Summary** ☐ **Other:**_____

4. My information that I agree to share may be sensitive. It may include diagnosis and treatment information. It may cover chronic diseases, mental/behavioral health conditions and alcohol or drug abuse. It may cover communicable diseases, lab results, sexually transmitted diseases, and genetic marker information.

5. This information for which I am authorizing disclosure will be used for the following **purpose**:
   ☐ **Personal Use** ☐ **Continued Care** ☐ **Legal Purposes** ☐ **Insurance Purposes** ☐ **Other** _____

6. I understand that I have a right to withdraw this authorization at any time. I understand that if I withdraw this authorization, I must do so in writing and give my written withdrawal to the entity making the disclosure. I understand that stopping this release will not apply to information that has already been released by this authorization. I understand that the withdrawal will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. This authorization will **expire**_____***(insert date or event)***. If I fail to specify an expiration date or event, this authorization will expire 90 days from the date it was signed.

8. 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 the federal privacy laws or regulations.

9. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used or disclosed under this authorization.

10. I understand that the entity making the disclosure may be paid for the costs of copying requested information.

_____ _____

Patient **OR** parent, guardian, authorized representative signature *(If not patient, please circle relationship above.)* Date

_____ _____

Witness Signature Date

FOR OFFICE USE ONLY: ☐ Picked Up (who)_____ ☐ Mailed ☐ Faxed ☐ Other_____

☐ Verified ID (ex. copy of driver's license, check signature, etc.) Comments:_____

Office Personnel:_____ Date:_____ _____ 4/19