Ivey Family Medicine

2905 S. Walton Blvd, #17, Bentonville, AR 72712 I P: (479) 657-6501 I F: (479) 657-6375

Authorization for Use and Disclosure of Protected Health Information

---

To comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) 1996 and state law, Ivey Family Medicine is requesting your authorization for use and release of health information.

Patient Information:

Name:_____ Date of Birth ____ / ____ / ____

I authorize Ivey Family Medicine to:

[ ] Release to [ ] Obtain from the following individual or organization

Name: _____ Ph:_____ Fax:_____

Address: _____

Purpose of Disclosure: _____

Type of Request:

[ ] Entire Record **OR** [ ] History & Physical [ ] Consultations [ ] Discharge Summaries

[ ] Laboratory Reports [ ] Radiology/Imaging [ ] Pathology Reports

[ ] Other (Please Specify) _____

INITIAL _____ [ ] I DO [ ] I DO NOT consent to release of information relating to psychiatric or psychological testing or treatment, alcohol and/or drug abuse diagnosis, prognosis and treatment and/or HIV (AIDS) testing and/or results, or such disclosure shall be limited to the following specific types of information:

_____

(Note: If this section is not completed, records of this type, if they exist for this patient, will not be released)

Expiration Date:

This authorization expires (180) days from the date of my signature or on _____ / _____ / _____

Authorizing Person:

_____ _____

Print Name Relationship to Patient

_____ _____

Signature Date

Patient, spouse, legal representative, or beneficiary (patient's spouse may authorize disclosure of the patient's health information only when the health information is for the sole purpose of processing an application for health insurance, for enrollment in a health care service place or an employee benefit plan, and where the patient is to be an enrolled spouse or dependent under the policy or plan)

_____ _____ _____

Signature Print Name Date

You are not required to sign this form as part of treatment or payment. You may refuse to sign this authorization. Patient or other party signing this authorization form has the right to receive a copy of the authorization form. Any information being released is for the specific purpose stated above and any other use of this information without the written consent of the patient is prohibited. The authorization may be changed or revoked, in writing, to prevent disclosure of information, except for any previous use of protected health information made in good faith under this authorization. IFM and its staff are hereby released from any legal responsibility or liability for disclosure of the above information covered under this authorization.