Arkansas Fertility & Gynecology

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Little Rock, Arkansas 72205
Phone: (501) 534-3764
Fax: (501) 954-9053
E-Mail:FertilityDoc@obgynmail.com

I, _____ authorize that my medical records be released **from** Arkansas Fertility & Gynecology to:

_____
(Name of physician, clinic, or hospital)

_____
(Address)

_____
(Phone Number / Fax Number)

The request and authorization applies to the following *(please check all that apply)*:

	Healthcare information related to the following treatment and / or condition:		
	Prior Lab testing; such as 'day 3 lab', AMH, thyroid function, infectious disease testing, etc.		
	Pap Smear Report(s)		IVF Cycle Records (Flow sheets / Gamete Sheets)
	All Operative and Pathology Reports from prior surgeries performed by AFGA		
	Other specific records, if not listed:		

Drug and / or Alcohol Abuse, and / or Psychiatric, and / or HIV / AIDS Records Release

I understand that my medical records may contain information about drug and/or alcohol abuse, psychiatric care, sexually transmitted disease(s), and/or other sensitive information, I agree to its release. YES _X___ NO____

Time Limit and Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the Privacy Site Coordinator or Privacy Officer. Unless revoked, authorization will expire one year from the date of signature.

Re-Disclosure

I understand that the information disclosed by this authorization is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This facility, its employees, officers, and physicians receiving this information are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization and my treatment or payments for services will not be denied if I do not sign this form unless specified above. I can inspect or copy the protected health information to be used or disclosed. I authorize the release of my records for use and disclose the protected health information specified above.

_____ ____/_____/_____ _____/_____/_____
Signature of Patient ***Date of Birth*** ***Date Signed***

_____-_____-_____
SSN