**Arkansas Fertility & Gynecology**

**9101 Kanis Road, Suite 300**
**Little Rock, Arkansas  72205**
**Phone:   (501) 534-3764**
**Fax:   (501) 954-9053**
**E-Mail:FertilityDoc@obgynmail.com**

I, _____ authorize my medical records be released **to**

Arkansas Fertility & Gynecology from**:**

_____
*(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: |
| | ALL healthcare information |
| | Pap Smear Report(s)    |    IVF Cycle Records (Flow sheets / Gamete Sheets) |
| | HSG Disc w/Viewer (we <u>do not</u> have a Dicom viewer system) Please MAIL disc to above address |
| | Other specific records, if not listed: |

**\*\* If record is >25pgs, please send via Mail or to E-mail address noted above\*\***

#### 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**

Dean Moutos, MD  ⬧  Francisco Batres, MD  ⬧  Sarah Humphries, APN