Retina Specialists of Arkansas, P.A.

Surgical and Medical Diseases of the Retina, Vitreous and Macula

Blandford Physicians Center
5 St. Vincent Circle, Suite 201
Little Rock, AR 72205
(501) 978-5500 FAX: (501) 978-5550

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I. By signing this authorization, I hereby authorize Retina Specialists of Arkansas, P.A. to use and/or disclose certain protected health information (PHI) about me to:

_____
(NAME OF ENTITY/PERSON TO RECEIVE INFORMATION)

_____
(STREET ADDRESS)

_____
(CITY, STATE, ZIP CODE)

_____
(FACSIMILE NUMBER, IF APPLICABLE)

II. This authorization permits Retina Specialists of Arkansas, P.A. to use and/or disclose the following individually identifiable health information about me. Specifically describe the information to be used and/or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information.

_____

_____

_____

III. The information will be used/disclosed for the following purpose: _____

IV. This authorization will expire on: _____

V.

- I understand that I am financially responsible for any fees associated with my request, if I have requested copies of my PHI, based on the current Arkansas state laws determining copy charges.
- I may not have to sign this authorization in order to receive treatment from Retina Specialists of Arkansas, P.A..
- I have the right to refuse to sign this authorization.
- When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.
- I have the right to revoke this authorization in writing, except to the extent that the Practice has acted in reliance upon this authorization prior to revocation. My written revocation must be submitted to the Privacy Manager at the office's address.

Signed by: _____/_____
(Signature of Patient or Legal Guardian) (Relationship to Patient, If Applicable)

_____ _____
(Print Patient's Name) (Date)

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION UPON REQUEST, IF INITIATED BY RETINA SPECIALISTS OF ARKANSAS, P.A.

MedRel:From RSA