AUTHORIZATION TO RELEASE HEALTH INFORMATION

Name:_____

DOB:_____ SSN: _____

Address: _____

Pursuant to federal guidelines concerning my right to confidentiality, I hereby authorize:

_____
Facility/Healthcare Provider

To release information to:

Helix Health
2210 W Kingshighway Suite 7
Paragould, AR 72450
870.236.2911 Phone
870.236.2912 Fax

The type and amount of information to be used or disclosed is as follows:

Entire medical record for _____
Dates of service

- Most current progress notes
- Lab reports
- Treatment record
- Current testosterone dosage and last administration date

_____
Initials

____I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Name:_____ DOB:_____

____This authorization may be revoked at any time by my written consent except to the extent that action has already been in the reliance thereon. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Privacy Officer at Helix Health. I understand that the revocation will not apply to the information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:

_____

If I fail to specify an expiration date, event or condition, this authorization will expire in 6 months.

____I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign this authorization. I understand that I can inspect or copy the information to be used or disclosed. I understand that any disclosure of information may not be protected under federal confidentiality rules. If I have questions regarding my health information, I can contact the Privacy Officer at the above address or telephone number.

____I understand that information disclosed pursuant to this authorization may be subjected to redisclosure by the recipient and may no longer be protected by federal privacy law.

_____

Patient Name or Representative

_____

Date/Time

_____

Signature of Patient or Representative

_____

Signature of Witness