The Surgical Clinic of Central Arkansas

Consent to Disclose PHI for Treatment, Payment, and Health Care Operations

This form must be completed by the individual whose protected health information is to be disclosed or by a parent or guardian if the person is a minor under state law.

Name: _____

Date of Birth: _____

I hereby authorize The Surgical Clinic of Central Arkansas to release the following personal health information for (check all that apply)

□ Medical service claims information.

□ Prescription, diagnostic, treatment, and/or care management services.

□ Reviews required by HHS or HIPAA-compliant health care operations.

The above information may be released by:

□ Phone □ Fax □ Mail □ E-Mail □ Friend or Relative_____

My Consent:

Effective: Today's Date: _____

I want this consent to:

□ Continue indefinitely □ Effective only until _____(date).

I understand that consent may be revoked by me at any time. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practice's Notice of Privacy Practices.

Signature of Patient: _____ Date: _____

Or Personal Representative: _____ Date: _____

Witness: _____Date: _____