# BOSTON MOUNTAIN RURAL HEALTH CENTER, INC.
## Authorization to Release Protected Health Information

| **Patient Information:** *(Please complete Name, DOB, and SSN information in section below.)* | | | |
|---|---|---|---|
| **Full Name:** | | **Date of Birth:** | |
| **SSN:** | | **Account No.:** | |

1. I authorize the release of the above named individual's medical records as directed below:
2. I authorize the entity indicated in the "Release Information From" section to make disclosure to the entity indicated in the "Release Information To" section below:

| **Release Information From:** | **Release Information To:** |
|---|---|
| ☐ Boston Mountain Rural Health Center, Inc.<br>PO Box 1030, Marshall, AR 72650 | ☐ Boston Mountain Rural Health Center, Inc.<br>P O Box 1030, Marshall, AR 72650<br>Ph. 870-448-5733 Fax. 870-448-3392 |
| ☐ Other:_____ | ☐ Other:_____ |
| _____ | _____ |
| _____ | _____ |

3. The type of information to be disclosed is as follows:

| **Dates of Service (optional): To: From:** |
|---|
| ☐**Clinic Notes** ☐**Laboratory Reports** ☐**Radiology Reports** ☐**Radiology Images** ☐**Pathology Reports** ☐**EKGs** ☐**Billing Information** ☐**Other:**_____ |

4. I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and alcohol or drug abuse.
5. This information for which I am authorizing disclosure will be used for the following **purpose**:
   ☐**Personal Use** ☐**Continued Care** ☐**Legal Purposes** ☐**Insurance Purposes** ☐**Other** _____
6. I understand that I have a right to withdraw this authorization at any time. I understand that if I withdraw this authorization, I must do so in writing and give my written withdrawal to the entity making the disclosure. I understand that stopping this release will not apply to information that has already been released by this authorization. I understand that the withdrawal will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
7. This authorization will **expire**_____***(insert date or event)***. If I fail to specify an expiration date or event, this authorization will expire 90 days from the date it was signed.
8. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by the federal privacy laws or regulations.
9. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used or disclosed under this authorization.
10. I understand that the entity making the disclosure may be paid for the costs of copying requested information.

_____ _____

Patient **OR** parent, guardian, authorized representative signature — Date

***(If not patient, please circle relationship above.)***

_____ _____

Witness Signature — Date

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**FOR OFFICE USE ONLY:** ☐ Picked Up (who)_____ ☐ Mailed ☐ Faxed ☐ Other_____

☐ Verified ID (ex. copy of driver's license, check signature, etc.) Comments:_____

Office Personnel:_____ Date:_____ _____