LITTLE ROCK Gynecology & Obstetrics, PLLC

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Authorization for Use/Disclosure of Protected Health Information

Patient Name: _____ **Date of Birth:** _____

I hereby voluntarily authorize the use/disclosure of information from my health record.

The information is to be disclosed by: Dr. Christie Cobb at Little Rock Gynecology and Obstetrics, PLLC
Practice

The information is to be provided to: Dr. Christie Cobb
Name of Person/Organization/Facility

1415 Executive Center Drive Little Rock, AR 72211
Address/Email/Fax#

The purpose of this disclosure is: Continuity of Medical Care

The information to be disclosed from my health record: check appropriate box(es)

- ☐ **Entire record**
- ☐ Pathology/Pap smear Reports
- ☐ Hospital Records
- ☐ Laboratory Reports
- ☐ Radiology Reports
- ☐ Progress Notes
- ☐ Health History

If you would like any of the following sensitive information disclosed, check the applicable box(es)

- ☐ Sexually Transmitted Diseases
- ☐ HIV/AIDS Testing/Results/Treatment
- ☐ Alcohol/Drug Abuse Treatment/Referral
- ☐ Mental Health: Not including Psychotherapy Notes

I understand I have the right to revoke this authorization by submitting my request in writing at any time to the Practice. The Practice must comply with my request except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. This authorization expires: (specify date/event) _____

I understand that the Practice will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party. I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule.

Signature of Patient: _____ **Date:** _____

Name of Authorized Personal Representative (if applicable): _____
Signature of Authorized Personal Representative: _____ Date: _____
Relationship to Patient: _____