

## AUTHORIZATION TO INDIVIDUALS

I, \_\_\_\_\_, give all physicians and professional staff employed by **Medical Associates of Northwest Arkansas, P.A.** permission to disclose the private health information set forth below to the following people at the request of one or more of these individuals.

The specific information these persons may receive is as follows: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

<i>Please Print:</i>	Name	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I also give **Medical Associates of Northwest Arkansas, P.A.** permission to leave a message(s) on my answering machine if they should need to remind me of an appointment, change an appointment, etc, and are unable to reach me in any other way.

\_\_\_\_\_ **Yes**      or      \_\_\_\_\_ **No**

I understand that **Medical Associates of Northwest Arkansas, P.A.** will not release any information to any person(s) not listed above.

In addition, I understand or acknowledge the following:

1. I have the right to revoke this Authorization at any time by giving **Medical Associates of Northwest Arkansas, P.A.** a written notice at the address set forth above.
2. I have received **Medical Associates of Northwest Arkansas** 's Notice of Privacy Practices.
3. My private health care information may be subject to re-disclosure by one or more of the persons named above and as such will no longer be protected.

This Authorization shall expire on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

<i>Please Print</i>	
Patient Name _____	D.O.B. _____

\_\_\_\_\_  
Signature
Date

In the event the Authorization is being executed by a personal representative, guardian, or parent, please print your name and relationship to the patient. \_\_\_\_\_