Authorization For Release of Protected Health Information

I, _____ give all physicians and professional staff employed by Medical Associates of NWA, PA, permission to disclose the protected health information set forth below to the following people at the request of one or more of these individuals**.**

Patient name (print):_____ **D.O.B.** _____

Information to be released to the below referenced entity:

☐**Complete Medical Record**
☐**Seek Medical Care**
☐ **or specific information:** _____

PLEASE PRINT: **NAME** **RELATIONSHIP TO PATIENT**

_____

_____

_____

I give Medical Associates of Northwest Arkansas P.A., permission to:

- Fax my child's **School Excuse** to his/her school.
  ☐ **Yes** ☐ **No**
- 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** ☐ **No**

In addition, I understand or acknowledge the following:

1. I understand that Medical Associates of Northwest Arkansas, P.A ., will not release any information to any person(s) not listed above.
2. I have the right to revoke this Authorization at any time by giving Medical Associates of Northwest Arkansas, P.A., a written notice. I understand this does not apply to the release of PHI pursuant to my prior authorization.
3. I have received Medical Associates of Northwest Arkansas's Notice of Privacy Practices
4. My protected health information may be subject to re-disclosure by one or more of the persons named above and as such may no longer be protected by federal or state law.

This authorization shall expire on the _____ day of _____, 20_____ and/or the following **Event**_____

Patient Signature:_____**DATE:**_____

In the event the Authorization is being executed by a personal representative, guardian, or parent, please print your name, relationship to the patient, and basis of authorization to act on the patient's behalf.

Print name _____**Relationship to Patient**_____

What is your authorization to act on the patient's behalf?_____

Signature _____ **Date** _____

mana
medical associates

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