4700 S. Thompson St.
Unit C-103
Springdale, AR 72764

479-571-6363 (Office)
479-684-3941 (Fax)
psychiatry@mana.md

NWA PSYCHIATRY
a MANA clinic

LANCE C. FOSTER, MD
Child, Adolescent & Adult Psychiatry
RANDALL STALEY, MD
Child, Adolescent & Adult Psychiatry
LAURA WILLIAMS, APRN
Psychiatric Mental Health Nurse Practitioner
NICHOLAS HOPKINS, APRN
Psychiatric Mental Health Nurse Practitioner

A referral to our clinic was made by: _____

Please complete this intake packet and return it to our office **within 10 business days**. We are presently booked out several weeks for new consultations. Having paperwork returned will assist us in assessing the urgency of the appointment and allows you to be put on a cancelation list for a sooner appointment.

We do not treat adult ADD/ADHD unless psychological testing has been done, we have the results and it confirms the presence of this. We do not accept commercial web-based testing, testing must be done by a psychologist.

When your packet is received and upon review if it is determined we will be unable to see you, we will let you and the referring provider know.

Completed packets can be returned in any of the following ways:

In Person or mailed to:

NWA Psychiatry
4700 S. Thompson Street
Suite C-103
Springdale, AR 72764

FAX:

479.684.3941

Email:

psychiatry@mana.md

Please feel free to contact our office with any questions about the paperwork or scheduling at

479.571-6363 option 4

Dr. Foster and Dr. Staley

4700 S. Thompson Suite C-103
Springdale, AR 72762
479.571.6363

Clinic Information:

NWA Psychiatry a MANA clinic provides care for adults and children. Our goal is to provide you with support and education. **Our psychiatrists provide ongoing medication management**. We will recommend ongoing counseling or therapy as needed.

Appointments, cancellations and missed appointment policy:

____ NWA Psychiatry requires a minimum of 24 hours' notice of cancellation prior to a scheduled follow up appointment. Cancellations of follow up appointments with less than 24 hours' notice will incur a $25 fee.

____ For new patient appointments, 48 hours' notice of cancellation is required. Cancellation or failure to attend the initial appointment may forfeit future visits and you will be billed $75. Your initial appointment visit will NOT be rescheduled until this fee is paid in full.

Please be advised that insurance companies will NOT reimburse for missed appointments fees.

____ All appointments are scheduled for a specific block of time. **If you arrive late for your scheduled appointment, it may have to be rescheduled**. Please be aware that keeping your appointment is necessary for medication refills (see medication refill policy).

In the event of inclement weather please call to confirm your appointment before attending.

Termination policy:

____ THREE (3) missed appointments without providing notice may result in termination from this practice. We also reserve the right to terminate for noncompliance.

Medication refill policy:

____ Medication refills coincide with when you are expected back for an appointment however, there might be circumstances in which a refill would be needed before your next scheduled appointment. Refill requests may take up to 3 business days to complete. Please note that we do NOT accept faxed requests from pharmacies and you are required to call the office to request your refill. **Not keeping follow up appointments could result in a disruption of your medication regimen.**

Insurance plans and financial policy:

____ NWA Psychiatry is a mental health provider and may be out of network with some insurance companies when other MANA clinic providers are in network. It is important to note that some insurance policies do not cover mental health care and It is your responsibility to check your benefits. Please remember that your insurance policy is a contract between you and the insurance provider; therefore, the clinic cannot guarantee payment of your claim(s) and must render the patient responsible for any services not covered by insurance.

Signature:_____Date:_____

Patient Name (PRINT):_____Date of birth:_____

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CHILD/ADOLESCENT INTAKE FORM

CHILD'S NAME: _____TODAY'S DATE:_____

DATE OF BIRTH: _____ RACE: _____ SEX: _____

OTHER NAME YOUR CHILD PREFERS TO BE CALLED:_____

NAME OF PERSON COMPLETING FORM:_____

RELATIONSHIP TO CHILD: _____

WHO REFERRED YOU TO OUR CLINIC:_____

MAY WE CONTACT THEM: _____ YES _____NO

PRIMARY CARE DOCTOR: _____

MAY WE CONTACT THEM: _____ YES _____NO

PRIMARY CONCERNS FOR CONSULTATION: _____

_____

_____

HOW LONG HAVE THESE CONCERNS BEEN PRESENT: _____

WHAT ARE YOUR GOALS FOR TREATMENT: _____

_____

_____

WHICH OF THE FOLLOWING SYMPTOMS/CONCERNS HAS YOUR CHILD EXPERIENCED IN THE LAST 60 DAYS:

_____ Sad or depressed mood _____ Withdrawn from family or friends

_____ Loss of interest in activities or hobbies _____ Feelings of guilt or worthlessness

_____ Feeling hopeless about the future _____ Sleep disturbance _____Change in appetite

_____Low energy or fatigue _____Trouble focusing or concentrating _____Thoughts of hurting self

_____Thoughts of suicide _____Thoughts of hurting or killing others _____Irritability

_____Severe angry outbursts (verbal or physical) _____Worrying too much

_____Feeling or acting restless _____Muscle tension _____Panic or anxiety attacks

_____Fear of looking stupid or being embarrassed _____Fear of offending others

_____Any other fears or phobias _____Drastic mood swings _____Episodes of decreased need for sleep

_____Extreme hyperactivity _____Racing thoughts _____Talking so fast it's hard to understand

_____Overly happy or euphoric _____Overly confident

_____Thoughts, feelings or images that come into the child's mind when he/she does not want them to?

_____Habits the child feels they must do even if he/she knows it does not make sense (for example excessive cleaning, checking, repeating, counting, organizing or hoarding things)?

_____Hearing voices that other people cannot hear _____Odd thinking or beliefs

_____Seeing things other people cannot see _____Feeling paranoid _____Poor body image

_____Trying to lose weight even though he/she is not overweight

_____Intentionally throwing up after eating _____Easily loses temper _____Easily annoyed

_____Defiant _____Argues with authority figures _____Annoying others on purpose

_____Blaming others for his/her mistakes _____Resentful, spiteful or vindictive _____Lying

_____Stealing _____Destroying property _____Setting fires _____Skipping school

_____Hurting other people or animals _____Difficulty learning

_____Trouble understanding social cues _____ Difficulty making/keeping friends

_____Sensitive to sound, light, touch or smell

HAS YOUR CHILD EXPERIENCED A TRAUMATIC EVENT: _____ Sexual abuse _____ Physical abuse

_____ Near death experience _____ Other traumatic event: _____

_____

SOCIAL HISTORY:

WHO LIVES AT THE CHILD'S PRIMARY RESIDENCE: _____ Mom _____ Dad _____Brother(s)

_____ Sister(s) _____ Step-parent _____ Grandmother _____ Grandfather _____ Aunt _____ Uncle

_____ Cousin(s) _____ Foster parent(s) _____ Foster sibling(s)

_____ Other: _____

IS THE CHILD ADOPTED? _____ YES _____NO IS THE CHILD AWARE? _____ YES _____NO

CURRENT SCHOOL: _____ GRADE: _____

DOES YOUR CHILD HAVE AN IEP OR 504 PLAN? _____ YES _____NO. If yes, please bring a copy to the first visit.

ARE THERE CURRENT BEHAVIOR CONCERNS AT SCHOOL? _____ YES _____NO

IF YES, PLEASE EXPLAIN: _____

_____

_____

HAS YOUR CHILD BEEN SUSPENDED OR EXPELLED FROM SCHOOL? _____ YES _____NO

ARE THERE ANY CURRENT LEGAL PROCEEDINGS INVOLVING THE CHILD? _____ YES _____NO

IF YES, PLEASE EXPLAIN: _____

_____

_____

MOM'S PREGNANCY HISTORY:

WAS THE PREGNANCY COMPLICATED BY ANY OF THE FOLLOWING, PLEASE EXPLAIN ANY YES ANSWER:

Preterm labor _____ YES _____NO _____

Substance abuse _____ YES _____NO _____

Emotional problems _____ YES _____NO _____

Medications _____ YES _____NO _____

Medical problems _____ YES _____NO _____

HOW MANY WEEKS GESTATION WAS THE PREGNANCY? _____ Weeks, _____Term, _____ Preterm

WAS THE DELIVERY (CHECK ALL THAT APPLY): _____ Vaginal _____C-Section _____ Induced

_____Spontaneous _____ Scheduled _____Emergent

ANY DELIVERY COMPLICATIONS? _____ YES _____NO. If yes, please explain: _____

_____

DEVELOPMENTAL HISTORY:

WERE EARLY CHILDHOOD DEVELOPMENTAL MILESTONES (SIT, WALK, TALK, TOILET TRAIN, ETC)?

_____Early _____On time _____Late

PLEASE LIST ANY DEVELOPMENTAL CONCERNS ABOUT YOUR CHILD: _____

_____

_____

PAST MEDICAL HISTORY:

HAS YOUR CHILD EVER HAD? _____ Headaches _____Seizures _____ Allergies (seasonal)

_____Diabetes _____ Thyroid condition _____Asthma _____ Other lung problems _____Cancer

_____ Head injury/concussion _____OTHER:_____

_____

HAS YOUR CHILD EVER HAD ANY SURGERIES? _____ YES _____NO If yes, please list surgeries and dates:

_____

_____

_____

_____

CURRENT MEDICATIONS

Name	Dosage	Frequency	When started

_____

_____

_____

_____

_____

_____

MEDICATION ALLERGIES _____ NONE _____YES (please explain) _____

_____

OTHER ALLERGIES _____ NONE _____YES (please explain) _____

_____

BIOLOGICAL FEMALES ONLY: HAS YOUR CHILD STARTED MENSTRUATION? _____ YES _____NO

IF YES, AT WHAT AGE _____

ARE PERIODS REGULAR? _____ YES _____NO DATE OF LAST MENSTRUAL CYCLE ____ / ____ / _____

IS THERE ANY CHANGE IN SYMPTOM SEVERITY WITH PERIODS? _____ YES _____NO

IF YES, PLEASE DESCRIBE_____

PAST PSYCHIATRIC HISTORY:

HAS YOUR CHILD EVER SEEN A PSYCHIATRIST OR THERAPIST/COUNSELOR BEFORE? ____ YES _____NO

Name of provider Dates seen Reason

_____

_____

_____

_____

HAS YOUR CHILD EVER BEEN ADMITTED TO A PSYCHIATRIC HOSPITAL? _____ YES _____NO

Name of the hospital Dates Reason

_____

_____

_____

_____

HAS YOUR CHILD EVER ATTEMPTED SUICIDE? _____ YES _____NO If yes, please describe: _____

_____

_____

DOES YOUR CHILD ENGAGE IN ANY SELF-HARM BEHAVIORS (LIKE CUTTING)? _____ YES _____NO

If yes, please describe: _____

_____

_____

HAS YOUR CHILD EVER BEEN VIOLENT OR AGGRESSIVE? _____ YES _____NO

If yes, please describe: _____

_____

_____

HAS YOUR CHILD EVERY USED ANY OF THE FOLLOWING? (MARK ALL THAT APPLY)

_____Tobacco _____Vaping _____Marijuana _____Alcohol

_____Opiates _____Benzos _____Ecstasy _____Methamphetamine

_____Cocaine _____Heroin _____Other:_____

IS YOUR CHILD CURRENTLY USING ANY OF THOSE MARKED ABOVE? _____Yes _____No

PLEASE MARK ANY PSYCHIATRIC MEDICATIONS YOUR CHILD HAS TAKEN IN THE PAST:

_____Alprazolam (Xanax) _____Diazepam (Valium) _____Mirtazapine (Remeron)

_____Amitriptyline (Elavil) _____Duloxetine (Cymbalta) _____Nortriptyline (Pamelor)

_____Amphetamine (Adderall) _____Escitalopram (Lexapro) _____Olanzapine (Zyprexa)

_____Aripiprazole (Abilify) _____Fluoxetine (Prozac) _____Oxcarbazepine (Trileptal)

_____Asenapine (Saphris) _____Fluphenazine (Prolixin) _____Paliperidone (Invega)

_____Atomoxetine (Strattera) _____Fluvoxamine (Luvox) _____Paroxetine (Paxil)

_____Bupropion (Wellbutrin) _____Guanfacine (Intuniv) _____Quetiapine (Seroquel)

_____Buspirone (BuSpar) _____Haloperidol (Haldol) _____Risperidone (Risperdal)

_____Carbamazepine (Tegretol) _____Iloperidone (Fanapt) _____Sertraline (Zoloft)

_____Citalopram (Celexa) _____Imipramine (Tofranil) _____Topiramate (Topamax)

_____Clomipramine (Anafranil) _____Lamotrigine (Lamictal) _____Trazodone (Desyrel)

_____Clonazepam (Klonopin) _____Levomilnacipran (Fetzima) _____Valproic Acid (Depakote)

_____Clonidine (Kapvay) _____Lisdexamfetamine (Vyvanse) _____Venlafaxine (Effexor)

_____Clozapine (Clozaril) _____Lithium _____Vilazodone (Viibryd) _____Desipramine (Norpramin)

_____Lorazepam (Ativan) _____Vortioxetine (Brintellix) _____Desvenlafaxine (Pristiq)

_____Loxapine (Loxitane) _____Ziprasidone (Geodon) _____Dexmethylphenidate (Focalin)

_____Lurasidone (Latuda) _____ Other: _____

FAMILY MEDICAL HISTORY including grandparents, parents, aunts, uncles, siblings, etc.

Have any of your child's relatives ever had any of the following:

	Yes	No	Relationship to child
Migraine/Chronic headaches			
Seizures			
Stroke			
High blood pressure			
Heart disease			
Heart attack			
Heart Murmur			
Lung disease			
Asthma			
Gastric reflux disease			
Diabetes			
High cholesterol			
Liver disease			
Kidney disease			
Thyroid disease			
Obesity			
Glaucoma			
Anemia			
Sudden unexplained death			
Dementia			
Cancer			

FAMILY PSYCHIATRIC HISTORY

Have any of your child's blood relatives ever had any of the following:

	Yes	No	Relationship to child
Depression			
Bipolar disorder			
Suicide			
Anxiety disorders			
Panic disorder			
Agoraphobia			
Obsessive Compulsive Disorder			
PTSD			
Eating disorder			
Schizophrenia			
Other psychosis			
ADHD/ADD			
Oppositional Defiant Disorder			
Conduct disorder			
Personality disorders			
Tourette's syndrome			
Autism spectrum disorder			
Alcoholism			
Substance abuse			
Psychiatric hospitalizations			

AUTHORIZATION TO RELEASE INFORMATION

Patient Name:_____ Date of Birth:_____

Caregiver Name(s):_____ Relationship to Patient:_____

Telephone (Home):_____ Cell:_____ Work:_____

Email:_____

Home Address:_____

City:_____ State:_____ Zip:_____

I request and authorize the release of medical information from:

PCP Name:_____

Clinic:_____ Phone:_____ Fax:_____

Therapist or Counselor:_____

Clinic:_____ Phone:_____ Fax:_____

Other Provider:_____

Clinic:_____ Phone:_____ Fax:_____

Release my records to:

NWA Psychiatry, a MANA clinic
4700 S. Thompson Suite C-103
Springdale, AR 72764
Phone: 479.571.6363 Fax: 479.684.3941

Please specify which records/information you would like released:

____ ALL RECORDS ____ CLINIC NOTES ____LABS _____ MENTAL HEALTH ____ SUBSTANCE USE ____ PAIN CONTRACT

By signing below, I understand:

I may revoke this authorization at any time. In signing this form, I authorize the release of my protected health information. I understand that upon my release, this health information is no longer protected and has the potential to be re-disclosed by the recipient. Treatment will not be denied to me if I do not sign this form. The authorization expires one year from the date of my signature.

Signature:_____ Date:_____

Northwest Arkansas Psychiatry a MANA Clinic

NWA PSYCHIATRY a MANA clinic

PATIENT REGISTRATION

www.mana.md

mana medical associates

PATIENT INFORMATION – Please Print

Patient Name_____
Last First Middle

Sex: ☐ M ☐ F Date of Birth _____ Social Security # _____

Address_____ Apt. _____

City_____ State_____ Zip_____

Home Phone _____ Mobile _____

Employer _____ Work Phone _____

Please check one: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Race: ☐ White ☐ African American ☐ Asian ☐ Native Hawaiian/Other Pacific Islander
☐ Native American Indian/ Alaskan ☐ Other Race _____

Ethnicity (Origin): ☐ Not Hispanic or Latino ☐ Hispanic or Latino Preferred (Primary) Language: _____

Have you been seen at this clinic before? ☐ **Yes** ☐ **No** If so, when? _____

Reason for today's visit _____

Primary Physician _____

Preferred Pharmacy_____ Street_____

EMAIL AUTHORIZATION

Email Address _____

By providing my email address above, I hereby agree to allow MANA to contact me by email with e-newsletters, wellness reminders, health news and updates regarding healthrelated services provided by MANA. I understand that MANA will not share the information provided above with outside companies.

EMPLOYER INFORMATION

Is today's visit work related? ☐ **Yes** ☐ **No**

Name of Employer _____ Employer Phone_____

Employer Address_____ City_____ State____ Zip_____

PATIENT NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received a copy of the Patient Notice of Privacy Practices from Medical Associates of Northwest Arkansas.

SIGNATURE_____ **DATE** _____

In the event this Acknowledgement form is being executed by a personal representative, guardian or parent, please print your name, date of birth, social security number and relationship to the patient here:

_____

*If you would like to authorize MANA clinic to release information to a **family member, spouse, or personal representative**, please complete an **Individual Authorization Form** provided by the receptionist.*

Patient Name _____ D.O.B. _____

PERSON RESPONSIBLE FOR PAYMENT

☐ My self/ My spouse (skip to the next section) OR: (List Father, Mother, Guardian or other)

Responsible Party _____ DOB_____

Relationship to Patient_____ SS#_____

Phone_____ Address_____ City_____ State____ Zip_____

HEALTH INSURANCE INFORMATION

1. If you are covered by one of the following insurance plans, please mark the appropriate plan:

☐ Aetna ☐ AMCO (or AMCO affiliate) ☐ Cigna ☐ Blue Cross Blue Shield ☐ Qual-Choice

☐ Novasys Choice Network / AR HealthNet ☐ Tyson ☐ United Healthcare ☐ Other

2. If you have one of the insurance plans listed above, please complete the following <u>for the person that carries the insurance</u>.

ID#_____ GP#_____ Phone#_____

Policy Holder's Name _____ DOB_____ SS#_____

Policy Holder's Address_____ City_____ State____ Zip_____

Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Step-Child ☐ Other

INSURANCE AUTHORIZATION & FINANCIAL AGREEMENT

I hereby authorize Medical Associates of Northwest Arkansas (MANA) to give my insurance company or companies all information they may require concerning my case, and I hereby assign to the physician(s) all payments for medical services rendered.

I understand that I am responsible for any amount not covered by insurance. I agree to pay any co-pay and amount due at the time of service.

Signed_____ Date_____

HOW DID YOU HEAR ABOUT US?

01 ☐ Recommended by a friend or family member.
02 ☐ Clinic web site, www.mana.md
03 ☐ Other web site _____
04 ☐ E-mail, Facebook or Twitter
05 ☐ Signs or location
06 ☐ Kids Directory Magazine
07 ☐ My employer
08 ☐ Citiscapes Magazine
09 ☐ Newspaper
10 ☐ Yellow Pages / phone directory
11 ☐ Received a postcard in the mail.
12 ☐ Referred by Doctor _____
13 ☐ Found the doctor listed in my Insurance directory.
14 ☐ Other *Please specify*_____

Thank you for choosing a MANA Clinic.

Medical Associates of Northwest Arkansas (MANA)

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page the next page (2) / back page.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

We do not market or sell personal information. We do not create or maintain psychotherapy notes at this practice.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/notic epp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Medical Associates of Northwest Arkansas (MANA) Privacy Officer:

Paula Maxwell, Chief Operating Officer
3383 N. MANA Court, Suite 201
Fayetteville, AR, 72703
Phone: (479) 571-6780
Email: privacyofficer@mana.md

Effective Date: September 23, 2013

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

☐ 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 the 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** _____

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medical associates