Barg Family Clinic

Authorization for Medical Records Release to Barg Family Clinic

Fax: 501-228-9828

I authorize the below to disclose certain protected health information to **BARG FAMILY CLINIC/Arkansas Family Care Network, P.A.**:

Name/Facility:	Phone:
Fax:	Address:
Patient Name:	Patient Date of Birth:

1. This authorization for release of information covers the period of healthcare from:
   - ☐ _____ to _____
     [Start Date] [End date]

   - OR -

   - ☐ All past, present, and future periods

2. I authorize the release of:
   - ☐ My complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse.)

   - OR -

   - ☐ My complete health record with the exception of the following information:
     - ☐ Mental Health records
     - ☐ Communicable diseases (including HIV and AIDS)
     - ☐ Alcohol/Drug abuse treatment
     - ☐ Other (please specify): _____

3. The purpose of this disclosure is:
   ☐ Continuity of Care ☐ Insurance ☐ Legal Reasons ☐ Personal Records ☐ Other

4. This authorization (check one):
   - ☐ Will expire when the following event or date occurs: _____

   - OR -

   - ☐ Will not expire unless it is revoked in writing.

   I understand I have the right at any time to revoke this Authorization in writing except to the extent that records have already been released in reliance on it. I understand my written revocation must be submitted to AFCN Clinic's Privacy Officer. A photocopy of this Authorization is as valid as the original.

5. I realize that when the above information is disclosed, it may be re-disclosed by the recipient, and there is no guarantee that it will continue to be protected by the federal HIPAA Privacy Rule.
6. I understand that AFCN will not condition treatment, payment for healthcare services, enrollment or eligibility for healthcare benefits on signing this Authorization.
7. AFCN, its employees and physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

Updated 8/17/2022