Danny B Holt, M.D.
J. Drew Dawson, M.D.
Brent E. Holt, M.D.
Alex J Baltz, M.D.
Brian Baltz, M.D.
Cammie Sifford, A.P.N.
Holly Brigance, A.P.N.

POCAHONTAS MEDICAL CLINIC
2901 Medical Center Drive
Pocahontas, AR 72455
Ph: 870-892-4467 Fax: 870-892-4407

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name_____DOB_____

SSN#_____Phone# _____

Address _____

City, State, and Zip_____

( ) I authorize Pocahontas Medical Clinic to RELEASE medical information to the following:
( ) I authorize Pocahontas Medical Clinic to OBTAIN medical information from the following:

Physician: _____ Facility: _____

Address: _____

City, State, and Zip: _____

Telephone: _____Fax: _____

SEND THE FOLLOWING RECORDS:
_____Office notes from date of service_____thru_____
_____Only items listed here_____
_____Entire record, including tests and consults
REASON FOR REQUEST:
Continuing Care_____ Insurance_____ Personal Use_____

By signing this authorization, I authorize to disclose certain Protected Health Information (PHI) about me in my medical records. This authorization will expire six (6) months from this date.
I do _____do not _____ consent to the release of information relating to psychiatric or psychological testing or treatment, alcohol/durg abuse testing/treatment/results/and HIV (AIDS) testing/treatment/results. I don not have to sign this authorization in order to receive treatment from the above named practice. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer of the above practice.

SIGNED BY: _____

Relationsip to Patient: _____

DATE: _____ CHART NUMBER: _____