Authorization to Release or Obtain Medical Information

Eras Women's Health
1125 N College Ave, Fayetteville, AR 72703
Phone: (479) 344-3313 | Fax: (479) 413-0218

Patient Information

Patient Name:		Date of Birth:	
Last 4 SSN:		Phone:	
Address:			
City:		State:	Zip:

Expiration Date

This authorization will automatically expire 120 days from the date of signature below, unless you specify another event:

Upon occurrence of _____

Purpose of Requested Use or Disclosure

_____

Dates of Service

☐ All dates of service ☐ From _____ To _____

Information to Be Released or Obtained

☐ Complete Medical Record ☐ Consultation ☐ Radiology Reports
☐ Discharge Summary ☐ Pathology Reports ☐ Laboratory Tests
☐ Operative Report ☐ EKG ☐ X-rays
☐ History & Physical ☐ ER Record ☐ Billing Records
☐ Other: _____

Sensitive Information

I understand that my records may include information about mental health, substance use, HIV/AIDS, or other communicable conditions.
☐ I authorize release ☐ I do not authorize release

Send Records To / Obtain Records From

Name:	
Address:	
City, State, ZIP:	
Phone:	

Fax:	
Email:	

Delivery Method: ☐ Mail ☐ Fax ☐ Secure Email

Exclusions (if any)

☐ Mental Health ☐ Substance Use ☐ HIV/AIDS ☐ STDs ☐ Communicable Diseases
☐ Other: _____

Patient Rights and Acknowledgment

- I may inspect or request copies of my records at any time.
- I may revoke this authorization in writing by notifying Eras Women's Health.
- Once information is released, it may no longer be protected by federal privacy laws.
- Eras Women's Health will not condition treatment or payment on signing this form.
- Reasonable fees may apply as allowed by law.

Signature

Signature of Patient:		Date:	
Printed Name (if different):		Legal Representative:	

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