Bray
Family
Medicine

303 Professional Park Drive
Arkadelphia, AR 71923
T: (870) 464 – 1515 F: (870) 464 - 1514

Authorization to Disclose Protected Health Information

Patient Name: _____

Date of Birth: _____ Last 4 Digits of SSN: _____ Phone: _____

Address: _____

I, _____ hereby authorize Bray Family Medicine to share information contained within my health record with the person(s)/organization(s) listed below. I understand the record may include information relating to mental healthcare, communicable diseases, and treatment of alcohol or drug abuse.

Person(s)/organization(s): _____

Address: _____

City: _____State: _____ Zip: _____ Phone: _____

I request the record to be provided in the following format:

☐ paper copy

☐ CD

☐ fax # _____

☐ unsecure email _____

This authorization to share my health information is valid:

☐ From _____ to _____

☐ All past, present, and future periods

☐ From the date of my signature until the following event: _____

I understand that:

- If I request the record to be provided by email that I undertake the following potential risks - the information may be obtained by someone else, the information can be opened and read by someone else, unencrypted information does not provide any assurance of privacy or security.
- The person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.
- I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to: Bray Family Medicine
  303 Professional Park Drive
  Arkadelphia, AR 71923
- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Printed Name Relationship, if not the patient