C. Don Greenway, M.D.
Debra F. Morrison,M.D.
Tom L. Meziere, M.D.
M. Bruce Johnson, M.D.

GastroArkansas

B. Douglas Stokes, M.D.
Angela K. Nutt, M.D.
Jaymie H. Pennington, M.D.
J. Craig Davis, M.D.

Request for Health Information

Patient Name: _____ Chart: _____ Date of Birth: _____

I request and authorize _____ to release health care information described below to:

GastroArkansas
409 N. University Ave.
Little Rock, AR 72205

Purpose(s) of this use/disclosure:

_____At the request of patient _____Other (please describe)

By initialing the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, if information and/or records exist:

___Please send entire medical record (all information) to the above named recipient.
___Transcribed Consultation Reports
___Billing Statements
___Transcribed Hospital Reports
___Pathology Reports
___Laboratory Reports
___Transcribed Procedure Reports
___Diagnostic Imaging Reports
___Verbal discussion of care with _____
___Other_____

The requested records or information is about healthcare provided during the following approximate time frame:
_____

Expect to the extent that action has already been taking in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to Privacy Officer, 409 N. University, Little Rock, AR 72205. Unless revoked earlier, this authorization expires 12 months from the date signed or upon (date or event) _____.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I may inspect or copy any information to be used or disclosed under this authorization.

I also understand that, if the person or entity receiving this information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under the applicable state or federal laws and regulations.

I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

_____ _____
Signature of Individual or Individual's Legal Representative Date

_____ _____
Print Name of Legal Representative (if applicable) Relationship of Legal Representative to Individual

(A copy of this signed form will be provided to the individual and/or the individual's legal representative.)