Tilley Family Medicine

495 Hogan, Ste. 1
Conway, AR 72034
Phone (501)327-1150
Fax (501)327-3427

J. Brad Tilley, M.D.
Nichole Paladino, APRN
Rhonda Robnett, APRN
Amber Tilley, APRN

Policies

Please complete your paperwork. If you are unable to complete your paperwork prior to your appointment time, you may be asked to reschedule. This is so the providers are not late for the person after you. Our office tries very hard to stay on time; however, there are situations that arise which may cause the provider to run later than usual.
If you will be late for a scheduled appointment, please call and notify the office. This is so we can possibly see other patients before you who may have arrived early. IF YOU ARE 15 MINUTES LATE YOU MAY BE ASKED TO RESCHEDULE. Again, this is so patients scheduled after you aren't made to be late as well.

Copays and deductibles are due at the time of service. We can no longer bill for them. If you are unable to pay in full at the time of service, you are expected to notify us prior to your scheduled appointment to make a monthly payment contract. If you do not have insurance, payment is expected in full at the time of service unless you have made arrangements prior to your appointment.

PLEASE call if you are unable to keep an appointment. We have an answering machine for after hours. We simply cannot afford to continue to schedule patients that do not keep appointments. After 3 missed appointments (without notification PRIOR to the appointment) you will be asked to find another doctor. We will provide EMERGENCY care for one month once you are notified you must find another doctor.

*****WE REQUIRE 5 BUSINESS DAYS NOTICE FOR ALL PRESCRIPTION REFILLS*****

All lab and radiology results are generally called to you within 7 days. We will contact you as soon as they are available to us. If you do not hear from us within 7 days of your lab and/or radiology, please contact us to find out why.

If you have problems with a medication or treatment plan, please call and ask to either speak with a nurse or schedule an appointment.

When scheduling an appointment, please let us know what you will be seen for. This allows us to schedule the appropriate amount of time.

We want you to feel welcome here and look forward to a long healthy relationship.

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Patient: (last)____________________ (first)____________________ (middle)____________________

Address:____________________________ (city)____________________ (state)______ (zip)__________

Email:______________________________________ Cell Ph#:____________________

Home Ph#:____________________ Work Ph#:____________________

Preferred Pharmacy:____________________ Location:____________________

Date of Birth:______________ Sex: (M) or (F) Age:________ Marital Status: ______________

SS#:____________________ Employer:______________________________

Spouse or Guardian:____________________ Contact Ph#____________________

Do you have Medical Insurance: Yes or No If yes, name of Insurance:____________________

Cardholder's Name:____________________ Employer:____________________

Cardholder's Date of Birth:______________

Secondary Insurance (if applicable):____________________

Cardholder's Name:____________________ Employer:____________________

Cardholder's Date of Birth:______________

In case of emergency, who would you like us to contact? (this person must be listed on your HIPAA)

Name:____________________ Ph#:____________________

Referred to our clinic by:____________________

Who is responsible for this bill?____________________

ASSIGNMENT & RELEASE: I, the undersigned, assign directly to Tilley Family Medicine all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. If I do not have medical insurance, I agree to pay in full at the time of service.

Patient Signature:______________________________ Date:____________________

PATIENT HISTORY FORM

To the patient or his representative: This form is intended to aid your attending physician in evaluating your past medical history. Please answer all appropriate questions as briefly as possible. This form is confidential, and information given will become a part of the permanent medical record. Please complete as soon as possible and give to your attending physician.

PERSONAL:

	Yes	No
Married	☐	☐
Divorced	☐	☐
Widowed	☐	☐
Live Alone	☐	☐

Other ______________________

EMPLOYMENT STATUS:

Employed	☐	☐
Retired	☐	☐

Occupation ______________________

EDUCATION:

High School Completion ______________________

College ______________ Years ______

College Graduate: Yes ☐ No ☐

Vocational: Yes ☐ No ☐

ALLERGIES:

DRUGS	YES	NO	TYPE OF REACTION
Penicillin	☐	☐	
Sulfa Drugs	☐	☐	
Aspirin	☐	☐	
Keflex	☐	☐	
Codeine	☐	☐	
Morphine	☐	☐	
Tetanus	☐	☐	
Latex	☐	☐	

Other Drugs (List) ______________________

Food Allergies (List) ______________________

Colonoscopy ________ Date ____________ Dr. ____________

Bone Density ________ Date ____________ Abnormal? ______

OB-GYN (Females Only):

Total Pregnancies ____________ Total Live Births ____________

Total Miscarriages ______________________

Onset of Menstrual Periods (Age) ______________________

Date of last Period or Age at Menopause ______________________

Any Child Over 8 Lbs. at Birth Yes ☐ No ☐

Last PAP Smear ______________________

Last Mammogram ______________________

Method of Birth Control? ______________________

HABITS:

Alcohol Yes ☐ No ☐

Quantity per week ______________________

Tobacco Yes ☐ No ☐

Packs of cigarettes per day ______________________

Years smoked ______________________

Patient's Name ______________________ **Age** ______

Telephone # ______________________

Other physicians you see or have seen ______________________

MEDICAL:	YES	NO		YES	NO
Anemia	☐	☐	Kidney Infection	☐	☐
Arthritis	☐	☐	Kidney Stones	☐	☐
Asthma	☐	☐	Mastitis (breast infection or other breast disease)	☐	☐
Blood Transfusions	☐	☐	Measles	☐	☐
Bronchitis	☐	☐	Migraine or Tension Headache	☐	☐
Cancer	☐	☐	Mumps	☐	☐
Chickenpox	☐	☐	Osteoporosis	☐	☐
Depression	☐	☐	Pleurisy	☐	☐
Diabetes	☐	☐	Pneumonia	☐	☐
Ear Infections	☐	☐	Prostate Infection (Male Only)	☐	☐
Emphysema	☐	☐	Rheumatic Fever	☐	☐
Epilepsy	☐	☐	Stomach Ulcers	☐	☐
Frequent Heartburn	☐	☐	Strep Throat	☐	☐
Gallstones	☐	☐	Strokes/Paralysis	☐	☐
Glaucoma	☐	☐	Thyroid Disorder	☐	☐
Heart Attack	☐	☐	Tonsillitis	☐	☐
Heart Disease	☐	☐	Tuberculosis	☐	☐
Hemorrhoids	☐	☐	Varicose Veins	☐	☐
Hepatitis	☐	☐	Whooping Cough	☐	☐
High Blood Pressure	☐	☐			
Hypoglycemia (Low Blood Sugar)	☐	☐			

Other:

____

SURGERY:	YES	NO		YES	NO
Tonsillectomy	☐	☐	Hysterectomy (Removal of Uterus)	☐	☐
Adenoidectomy	☐	☐	Appendectomy	☐	☐
Thyroid Surgery	☐	☐	Hemorrhoid Surgery	☐	☐
Gallbladder Removal (Cholecystectomy)	☐	☐	Hernia Repair	☐	☐
Breast Biopsy or Removal	☐	☐	Removal of Any Skin Tumor	☐	☐

Other Surgery:

____

TRAUMA/INJURIES:	YES	NO
Cerebral (Brain) Concussion	☐	☐
Fractures (Broken Bones)	☐	☐
List:		
______________	☐	☐
______________	☐	☐
______________	☐	☐
Dislocations (Joints):	☐	☐
______________	☐	☐
______________	☐	☐
______________	☐	☐
Back Injury	☐	☐

	Always	Never	Sometimes
Seat Belt Use	☐	☐	☐
Child Restraint Use for Age 4 or Less	☐	☐	☐

MEDICATIONS:

List any medication taken daily or on a regular basis:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________
8. ______________________
9. ______________________
10. ______________________

EXERCISE:

Type ______________________

How Long at a Time __________ Times Per Week __________

IMMUNIZATIONS:

Last Tetanus (year) __________

Last Flu Shot __________

Have You Had:

Hepatitis B Vaccination __________

Pneumonia Vaccination __________

PPD (TB Test) __________ if so, year __________

DIET:

Number of times you eat red meat, "fast food" or fried food in a week __________

Number of fruits and vegetables you eat daily __________

Number of servings of milk, cheese, yogurt or ice cream in a day __________

CHOLESTEROL:

last time checked __________

low __________ normal __________ high __________

FAMILY HISTORY:

Father: Living ________ Age ________

Dead ________ Age ________

Medical problems: ______________________

____

If dead, cause of death: ______________________

____

Mother: Living ________ Age ________

Dead ________ Age ________

Medical problems: ______________________

____

If dead, cause of death: ______________________

____

Brothers and Sisters:

Name	Living	Dead	State of Health or Cause of Death:
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

Children:

Name	Living	Dead	State of Health or Cause of Death:
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

Have any of your blood relatives (parents, children, grandparents, uncles, aunts, etc.) ever had any of the following?

	Yes	No	If yes, **what relative?**
Diabetes	☐	☐	
Cancer (if so, what kind?)	☐	☐	
Tuberculosis	☐	☐	
High Blood Pressure	☐	☐	
Arthritis	☐	☐	
Kidney Disease	☐	☐	
Epilepsy (Fits)	☐	☐	
Heart Disease	☐	☐	
Heart Attacks	☐	☐	
Lung Diseases (Emphysema)	☐	☐	
Strokes	☐	☐	
Blood Disease	☐	☐	
Thyroid Disease	☐	☐	
Hepatitis	☐	☐	
Other Infectious Diseases	☐	☐	

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Please fill out this form if you smoke cigarettes, cigars or use smokeless tobacco:

I, ____ understand that smoking cigarettes and cigars, or the use of smokeless tobacco is extremely dangerous to my health. I know that it causes lung cancer and is a causative factor in many other cancers. It causes heart disease, emphysema, circulation problems, worsens high blood pressure and makes me more likely to have frequent upper respiratory infections such as sinusitis, bronchitis, and even pneumonia. Smoking decreases my exercise tolerance, stains my teeth and hands, and gives me bad breath.

I further realize that quitting smoking or using smokeless tobacco is the single best thing I can do to improve my overall health. My risk of cancer, heart disease and other illnesses can decrease to that of a non-tobacco user in just a matter of years.

I presently smoke/dip ____packs (cans) per day/week. I have smoked for ____years. I have tried to quit smoking ____times. The longest period I have quit was __________. The major reason I have difficulty quitting is

____.

Please choose one:

____I don't want to quit smoking/using smokeless tobacco

____I want to quit by: ____________

____I want to quit now.

I agree that I should stop smoking/using smokeless tobacco. I further agree to cut down on my tobacco use from this time forward and make sincere efforts to quit in the near future, with an ultimate goal of quitting by:____________

Patient's Signature____ Date______________

I understand how difficult it can be to stop using tobacco. I also know that I can help you quit or cut down, in order to improve your health and prevent serious illness. I agree to counsel, inform, support and encourage you and discuss with you the proper ways you can meet this very important goal.

Physician's Signature____Date______________

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Attached is a copy of Tilley Family Medicine's Privacy Practices and signature pages.

On the last signature page you will need to list anyone with whom we may share your Protected Health Information.

(For example: Spouse, Children, Family Members, etc)

Thank You

Tilley Family Medicine

Tilley Family Medicine – Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice provides you with information on the steps this Clinic has taken to protect the privacy of your Protected Health Information (PHI). It also describes some of the privacy rights you have and how you can exercise those rights. Please read this carefully. If you have any questions, please ask the receptionist if you can speak with Brenda Stone, who is out Privacy Official, or you can call her at 501-327-1150.

Your Protected Health Information(PHI) is information that is created or received by this Clinic, transmitted by electronic form or maintained in any medium, that identifies you or could reasonable identify you, and relates to your past, present, or future:

1.) physical or mental health or condition;
2.) your health care treatment; or,
3.) the payment of your healthcare services.

I. **USES AND DISCLOSURES:**

A. The following are examples of some ways the Clinic may use and disclose your Protected Health Information (PHI) based on your signing our Clinic's consent form:

1.) Treatment
In order to adequately provide for your health care needs, your PHI will be used and disclosed within the Clinic by the Clinic's employees and independent contractors as necessary to treat, evaluate, and provide you with health care services. This may also include the need for us to obtain PHI from your previous health care providers in to treat you properly.

2.) Payment.
To receive payment for our services, the Clinic will have to disclose certain PHI to your Health Plan or Insurer. This could require disclosure prior to treatment to obtain precertification from your Insurer to perform a procedure or it could be post treatment disclosure to obtain payment for the services provided. Your Insurer also has a right to demand access to your records to determine eligibility for making pre-existing condition determinations or for conducting quality control inspections. PHI may also be disclosed to comply with workers compensation laws and similar programs. The Clinic may also use and disclose limited PHI to consumer reporting agencies relating to collection of payments owed to the Clinic.

3.) Clinic Operations.
To ensure the proper functioning of our clinic, it may be necessary from time to time that certain PHI be used and disclosed. For example, we may use a sign-in sheet at the front desk to keep track of which patients have arrived. We may call out your name when it is time for you to come back to an exam room. Our employees and independent contractors may have to access our medical records for

certain business operations. Our clinic may allow high school, college, or medical school "shadow" students in the clinic and they may be exposed to certain PHI.

4.) Referrals.
In order to effectively refer you to another physician, we will have to release certain PHI to that physician to assist that physician in your treatment and to make the necessary appointment.

5.) Consultations.
There may be occasions where the Clinic may desire to consult another professional about your treatment to get a second opinion. In those situations, the Clinic will always attempt to maintain your privacy to the maximum extent possible, recognizing that it may not always be an option.

6.) Business Associates.
As part of our business operations, we have to enter into agreements with third parties to assist us. These third parties can be accountants, computer consultants, transcriptionists, etc. These third parties may have access to certain PHI. Prior to any of our Business Associates having access to PHI, they will sign an agreement that requires them to have procedures in place to protect the privacy of your PHI.

B. The following are examples of some of the ways the Clinic may use and disclose your Protected Health Information (PHI) based on your opportunity to orally assent or object:

1.) Family Members of Individuals Involved in Your Care.
This Clinic may use and disclose PHI to your family members or other individuals who are involved in your care when the Clinic believes it is necessary to provide your location, general health condition, and in the case of your death. An example might be if you needed a ride home, we might contact a relative to provide you a ride.
You may inform our Privacy Official in writing if you choose to object to this use or disclosure.

2.) Faculty Directories.
We may use PHI to maintain a listing of the name, location, general condition, and religious affiliation of individuals in our facilities and disclose it to religious personnel and to others who specifically request the information by identifying the individual by name. You may inform our Privacy Official in writing if you choose to object to this use or disclosure.

3.) Release of Immunization Records to Schools.
The Clinic may release immunization records directly to schools with only an oral authorization from a parent or person acting in the place of a parent.

C. The following are examples of some of the ways the Clinic may use and disclose your Protected Health Information (PHI) without your consent, authorization, or opportunity to assent or object:

1.) Legal Obligations.

This Clinic will use and disclose PHI when legally required. If this situation occurs, we will notify you and will limit the PHI to the minimum necessary to comply with the law. Some examples are as follows: court orders, subpoenas, reporting suspected abuse or neglect, reporting adverse results to the Food and Drug Administration, reporting exposures to communicable diseases, certain criminal activity, and military activity.

2.) Inmates.

If you are an inmate, this Clinic may use or disclose PHI to the facility and correctional officers when appropriate.

3.) Emergencies.

In an emergency treatment situation, our Clinic may use or disclose PHI. Our Clinic's health care professional will obtain your consent as soon as practicable following the emergency.

4.) Communication Barrier.

If there is a substantial communication barrier, this Clinic may use of disclose PHI for treatment, payment, or health care operations when circumstances would infer consent.

D. The following are examples of some of the ways the Clinic may use and disclose your Protected Health Information (PHI) based on your signing our Clinic's Authorization form:

Other uses and disclosures of your Protected Health Information (PHI) that do not fit into one of the above categories shall only be allowed upon your signing one of our Clinic's specific authorization forms. An example of when this may be necessary is if you would want our Clinic to release your medical records to your employer. You would need to come in and complete a specific authorization for us to disclose your PHI to your employer, unless of course your employer is your health insurer. If your employer is your private health insurer, then it would have access to your medical records through your consent form.

You have the right to revoke any authorization, however, the revocation will not be effective to the extent the Clinic has relied on it.

E. Certain disclosures cannot be made without your specific authorization.

1.) Psychotherapy notes.

Most uses and disclosures or psychotherapy notes are prohibited unless you specifically authorize their release.

2.) Sale of PHI.

The sale of PHI occurs when the Clinic makes a disclosure of PHI and directly or indirectly receives remuneration from the recipient in exchange for the PHI.

3.) Use of PHI for Marketing.

The Clinic may use PHI for marketing purposes.

F. Additional disclosures include.

1.) Use of PHI for Fundraising.
PHI may be used for fundraising purposes. You have the right to opt out of receiving such communications by contacting the Privacy Official.
2.) Disclosure of PHI to Plan Sponsor.
PHI may be disclosed to a plan sponsor, in cases of a group health plan, health insurance, or HMO.
3.) Disclosure of PHI for Underwriting Purposes.
PHI may be disclosed for underwriting purposes, in which case, PHI that is genetic information will be excluded from such disclosure.

II. RIGHTS

A. Right to Request a Restriction of Uses and Disclosures.
Your have the right to notify our Privacy Official in writing that you request a restriction on our use and disclosure of your Protected Health Information (PHI). Our clinic does not have to grant your request and we can condition treatment on your willingness to consent to our uses and disclosures of your Protected Health Information (PHI). We will notify you in writing whether we will grant or deny your request. If your request is granted, we may choose, at a later date, to deny continuing the restriction and if so, we will notify you in writing of that decision.

B. Right to Request Confidential Communications.
You have the right, by making a written request, to request that all our communications with you concerning your Protected Health Information (PHI) be confidential. Your request must tell us how or where you wish to be contacted. We are required to accommodate only reasonable requests. We cannot ask you the reason for such a request.

C. Right to Inspect and Copy.
You have the right, by making a written request, to inspect and copy your Protected Health Information (PHI). There are a few exceptions to this rule. We must approve or deny your request within 30 days, although a one- time 30 day extension is allowed. In the case of a denial, we will provide you with an explanation for the denial.
We will charge a reasonable fee for copying, preparation, and postage (if mailed to you), which must be prepaid. If the Clinic has electronic medical records, you also have the right to request that your PHI be provided to you in an electronic format.

D. Right to Amend.
You have the right, by making a written request, to request that we amend your Protected Health Information (PHI) that we created. If you make such a written request, we will act on your request and respond in writing within 60 days. Should your request be denied, an explanation will be provided. You will have the right to appeal any denial to amend PHI.

E. Right to Receive an Accounting.
You have the right, by making a written request, to request that we provide you with an accounting of our disclosures of your Protected Health Information (PHI). The accounting

will be provided within 60 days of the request. Standard disclosures are not included in the accounting. Examples of standard disclosures would be disclosures to you, for treatment, payment, and health care operations. The first accounting in a 12 month period is free. Any subsequent request for an accounting in the same 12 month period will result in a reasonable, cost-based fee.

F. Right to Receive Copy of Notice.
You have a right to receive a paper copy of our Notice of Privacy Practices. You may pick one up at the front desk.

G. Right to File a Complaint.
The law requires us to comply with HIPAA and our Notice of Privacy Practices. If you feel we are not in compliance, you have the right to file an anonymous complaint with our office. We have an anonymous drop box in our waiting room. You also can file a complaint by notifying our Privacy Official in writing. We will not retaliate in any manner due to a complaint. We value your opinion. You also have a right to file a complaint with the Secretary of the Department of Health and Human Services, who is charged with enforcement of this regulation.

H. Right to Restrict Release of PHI for Certain Services.
You have the right to restrict the disclosure of information regarding services, treatment or other items for which you have paid in full or on an out of pocket basis. This information can be released only upon your written authorization.

I. Right to Be Notified in Case of a Breach of PHI.
You have the right to be notified of any breach of your unsecured PHI.

III. DISCLOSURE STATEMENTS

A. This clinic intends to use and disclose Protected Health Information (PHI) in the additional following ways, on which treatment is conditioned:
1.) To have you sign in on a sign in sheet;
2.) To allow our staff to call out your name when it is time for you to come back for an exam, treatment, or consultation;
3.) To send out reminders of appointments;
4.) To provide alternative treatment information;
5.) To leave messages on voicemail systems with appointment reminders; and,
6.) To contact you at the phone numbers you provide and leave messages to reschedule appointments or to leave lab results.

B. The Law requires this Clinic have privacy protections for Protected Health Information (PHI) and to give you Notice of its legal responsibilities to individuals.

C. This Clinic has to follow the terms and conditions contained in its Notice of Privacy Practices.

D. The Clinic retains the right to make retroactive changes to its Notice of Privacy Practices. This means that if the Clinic changes it's Notice of Privacy Practices and thus changes it's Privacy Practices and Procedures it can and will apply those changes to Protected Health

Information it received, obtained, and created prior to those changes if it chooses and states so in this Notice.

E. Any individual who would like a copy of any revised Notices of Privacy Practices shall submit such a request in writing to the Privacy Official whose name is listed on the first page of this Notice.
F. This Notice is effective the 1st day of September, 2013.

*Revised and updated on August 16, 2017

I have been given a copy of Tilley Family Medicine's Privacy Practices to read.

Patient Signature_________________________________ Date_______________

(If under 18 years old, Parent/Guardian Signature)

HIIPAA GENERAL CONSENT

I hereby give my consent for Tilley Family Medicine to use or disclose my Protected Health Information (PHI) and/or to access the Prescription Monitoring Program to carry out treatment, payment, or any other health care operations. I understand that my Protected Health Information is as follows:

Information that is oral or recorded in any form that relates to my past, present, or future, physical or mental health condition, my past, present, or future health care treatment, or the payment of my past, present, or future health care treatment, that is or could reasonably identify me and is transmitted in an electronic form or maintained in any form.

This Protected Health Information could include information that this Health Care Provider created, received from me, received from another Health Care Provider, received from a Health Plan, Health Care Clearing House, Insurance Company, Employer, or any other source, and could include demographic information about me.

I have been informed that my Health Care Provider has adopted a complete statement of its privacy practices, which are contained in Tilley Family Medicine's Notice of Privacy Practices. I have received a copy of the Notice of Privacy Practices and have had an opportunity to review them and ask any questions concerning them before signing this HIPAA Consent. I understand that my Health Care Provider has the right to change them at any time without advance notice to me. I can request a copy of my Health Care Provider's latest Notice of Privacy Practices by calling the office, stopping by and picking up a copy, stopping by and reading the Notice that is posted in my Health Care Provider's waiting room, or asking that my name be put on a list to be mailed a copy of any updated Notice of Privacy Practices should my Health Care Provide make changes to the Notice of Privacy Practices.

I understand that I have the right to not give this consent; however, I also understand that my Health Care Provider does not have to treat me if I do not sign this consent.

I understand that I have the right to request restrictions on this consent and to request limits on when and how my Health Care Provider uses and discloses my Protected Health Information, however, I understand my Health Care Provider is not obligated to agree to the restrictions or limitations I request.

I understand that if my Health Care Provider agrees to a restriction, my Health Care Provider shall be bound by the restriction until I release my Health Care Provider from that restriction.

I understand that I have the right to revoke my consent; however, it shall not be considered revoked to the extent my Health Care Provider has relied on it.

I hereby consent to all the uses and disclosures in my Health Care Provider's Notice of Privacy Practices.

____
Patient – Printed Name

____
Patient – Signature

____
Date

____
Personal Representative of Patient

SPECIFIC AUTHORIZATION

I hereby give my authorization for Tilley Family Medicine to use or disclose my Protected Health Information to carry out treatment, payment, or any other health care operations.

I understand that my Protected Health Information is as follows:

Information that is oral or recorded in any form that relates to my past, present, or future, physical or mental health condition, my past, present or future health care treatment, or the payment of my past, present, or future health care treatment, that is or could reasonably identify me and is transmitted in an electronic form or maintained in any form.

This Protected Health Information could include information that this Health Care Provider created, received from me, received from another Health Care Provider, received from a Health Plan, Health Care Clearing House, Insurance Company, Employer, or any other source, and could include demographic information about me.

I specifically give this Health Care Provider authorization to use or disclose my Protected Health Information to the following persons for the following purposes:

____

____

____

____

____

I understand that I have the right to revoke my authorization; however, it shall not be considered revoked to the extent my Health Care Provider has relied on it. I understand that once this information has been disclosed to third parties, there may not be any safeguards to prevent the third party from further disclosing the Protected Health Information.

I request this authorization expire on the following date: ______________________. I may revoke it sooner in writing by contacting the Privacy Official, Brenda Stone. I may also reach him/her by phone at 501-327-1150. I understand the Health Care Provider can condition my treatment or evaluation on my signing this authorization.

___________________________	___________________________
(Patient – Printed Name)	(Patient- Signature)
___________________________	___________________________
(Date)	(Personal Representative of Patient)