THE WINSTON CLINIC, P.A.

P.O. BOX 100
SHERIDAN, AR 72150
PHONE (870)942-3000 FAX (870)942-3005

Authorization for the Use or Disclosure of Protected Health Information

AUTHORIZATION SECTION PATIENT DATE OF BIRTH _____

I, _____, hereby authorize the use and disclosure of all my health information.

(PRINT PATIENT NAME)

I authorize the following persons to make and receive these disclosures of my health information:

_____ _____

(name of person(s) that can request your health information)(include relationship to patient)(EX: John Doe- Dad)
PLEASE PRINT NAME LEGIBILY

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I may revoke this authorization at any time by signing the revocation section of this form and returning it to The Winston Clinic, P.O. Box 100, Sheridan, AR 72150. I further understand that any such revocation does not apply to the extent that persons authorized to use of disclose my health information have already acted in reliance on this authorization.

I understand that this authorization will automatically expire in **ONE YEAR** from signing this document.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment, my eligibility for benefits, etc., will not depend in any way on whether I sign this authorization or not.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

I understand that The Winston Clinic, P.A. will receive compensation for the uses and disclosures that I have authorized.

Signature: _____ Date:_____

REVOCATION SECTION

I hereby revoke this authorization.

Signature:_____ Date:_____