**Paragould Family Care, PA**
**5 Market Pl | Paragould, AR 72450**
**Phone: (870) 236-4001 | Fax: (870) 236-4009**

# AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name: _____ Date of Birth:_____

Phone Number_____ Last Four Digits of Social Security Number:_____

Address_____

Email Adress_____

## PARTY TO RECEIVE INFORMATION:

I hereby authorize: _____
Entity, person(s), or class of persons

To release to: Paragould Family Care, PA and its physicians' employees and agents

**TYPES OF INFORMATION:**

Date(s) of Service Requested: _____

_____ Summary of Medical Record
_____ Entire Medical Record
_____ Radiology
_____ Laboratory
_____ Operative/Pathology Report
_____ Immunization Records
_____ Other Information: _____

I understand the record may include information relating to mental healthcare, communicable diseases, and treatment of alcohol or drug abuse.

I request the record to be provided in the following format:
_____ paper _____ CD _____ secure portal _____ fax _____ unsecure email

I understand 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

_____ _____
Patient Signature Date

_____ _____
Legal Representative, if not patient Date