GENERAL AUTHORIZATION

I hereby give my authorization for Throneberry Family clinic 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 is 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:

_____ ALL RECORDS

_____ OTHER (Please Specify) _____

Records Transferred To:

_____ Throneberry Family Clinic
2869 College Avenue
Conway, AR 72034
Ph. (501) 327-2611
Fax. (501) 336-9763

Other: _____(name)
_____(address)
_____(city,st,zip)
_____(phone)
_____(fax)

_____ Myself

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. This authorization shall remain in effect until I revoke it in writing by contacting the Privacy Official, Lisa Hust, I may also reach her by phone at 501-327-2611. I understand the Health Care Provider can condition my treatment or evaluation on my signing this authorization. I understand that I have the right to request in writing to inspect and copy my PHI. There are a few exceptions to this rule. My Health Care Provider must approve or deny my request within 30 days and in the case of a denial, provide me an explanation of the reason. My Health Care Provider may charge a reasonable fee for copying, preparation, and postage (if mailed to me), which must be prepaid.

_____ _____
Patient – Printed Name Patient – Signature

_____ _____ _____
Date Date of Birth Personal Representative of Patient (if under 18 years)