BENTONVILLE SPORTS MEDICINE

HIPPA WAIVER & AUTHORIZATION

(Health Insurance Portability and Accountability Act)

Your health and medical information is considered sensitive and private and is afforded protection under the law. However, there are circumstances when you may want to provide this information to another individual or entity (e.g. healthcare professionals). In those circumstances, you will generally sign an authorization to disclose health information. These authorizations can be quite broad or quite limited. The purpose of this form of Authorization to Disclose Health Information is to allow **BENTONVILLE SPORTS MEDICINE** to be able to secure the medical information necessary in regards to your health. In addition, this form complies with the HIPAA (Health Insurance Portability and Accountability Act) Privacy Rules. For more information on medical information privacy you can contact: U.S. Department of Health and Human Services, Office of Civil Rights: (866) 627-7748 OR www.hhs.gov.

AUTHORIZATION TO RELEASE INFORMATION

I, _____, authorize the use or disclosure of my health information to **BENTONVILLE SPORTS MEDICINE** appointed by me as a Health Care Agent, in his or her sole discretion. I authorize and release to **BENTONVILLE SPORTS MEDICINE** any and all other medical information requested by such agent or to the persons named herein below:

Name: _____ Name: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and recover and destroy all copies of this document that I have previously distributed. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed.

I acknowledge receipt of a signed copy of this authorization and execute it on _____ [date].

Name: _____

Witnessed: _____

Relationship: _____