Creekside Center for Women
5330 Willow Creek Drive
Springdale, AR 72762

Kent A. Mason, M.D., F.A.C.O.G.
Michael P. Clouatre, M.D.
Ashley E. Mason, M.D., F.A.C.O.G.

Voice 479.582.9268
Facsimile 479.973.9229
www.creeksideobgyn.com

Darrin D. Cunningham, D.O., F.A.C.O.O.G.
Greg Reiter, D.O., F.A.C.O.O.G.

Authorization to Release or Obtain Medical Information

Patient Information

Patient Full Name:	
Patient's Date of Birth:	
Patient's Social Security Number:	**Phone #:**
Address, City, State & Zip:	

I hereby authorize CREEKSIDE to release information **TO**:		I hereby authorize CREEKSIDE to obtain information **FROM**:	
Physician or Facility Name:		**Physician or Facility Name**	
Address:		Address:	
City, State & Zip Code:		City, State & Zip Code:	
Telephone Number:		Telephone Number:	
Facsimile Number:		Facsimile Number:	

The purpose for this disclosure is: _____ **ARE YOU PREGNANT?** _____

My authorization extends only to those data elements/documents initialed below:

_____Complete Medical Record
_____Record of visits
_____Record of visit for specific date or dates or condition. Specific dates or condition are limited to: _____
_____Copies of records or reports to the above named
_____Progress Notes
_____Photographs, digital or other images
_____Discharge Summary
_____History and Physical Examination
_____Consultation Reports
_____Mental Health and/or alcohol or drug abuse treatment
_____AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) information
_____Hepatitis Information

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available from the receptionist.
4. Creekside Center for Women, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this Authorization.
6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____ _____
Patient Printed Name Date

_____ _____
Signature of Patient or Legal Representative Expiration Date (If other than one year from date above)

_____ _____
Witness Date

Please Note: The first set of Medical Records will be delivered at no cost as a courtesy to our patients. Each additional Copy of your Medical Record will cost a minimum of $5.00 plus $.25 per page over six pages.

For Office Use Only

Method of Delivery:	Facsimile	Pages:	
	 U.S. Postal Service	Date:	
	Courier	Processor:	