Arkana Laboratories

Authorization to Release Patient Information

Patient Information:

Patient Name: _____ Social Security #: _____ Gender: M ☐ F ☐

Date of Birth (MMDDYYYY): _____ Phone #: _____ Email (optional) : _____

Release Information To:

By signing this authorization, I authorize Arkana Laboratories to use and/or disclose certain protected health information (PHI) about me to:

Name of entity to recieve this information: _____

Address: _____ Phone #: _____ Fax #: _____

Information To Be Released:

This authorization permits Arkana Laboratories to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

☐ Paraffin Block ☐ Images ☐ Slides ☐ Report ☐ All Materials

Purpose Of Release:

The information will be used or disclosed for the following purpose:

☐ Treatment/Continued Care ☐ Disability Determination ☐ Other: _____

☐ Legal Purposes ☐ Payment of Insurance Claim

Authorization Expiration:

This authorization expires on the following date: _____

I understand that:

- The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing this PHI.
- I do not have to sign this authorization in order to receive treatment from Arkana Laboratories. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.
- I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

  Arkana Laboratories
  Attn: Privacy Officer
  10810 Executive Center Drive, Suite 100
  Little Rock, AR 72211

_____ _____

Signature of Patient or Patient Representative Date

_____ _____

Print Representative Name Relationship to Patient