



**AUTHORIZATION TO RELEASE HEALTH INFORMATION**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City & State:** \_\_\_\_\_

**ZIP:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Parent/Guardian Name:** \_\_\_\_\_

**Sending Facility/Person:**

**Receiving Facility/Person:**

\_\_\_\_\_  
**Facility Name** **Fax number**

\_\_\_\_\_  
**Facility Name** **Fax number**

\_\_\_\_\_  
**Address** **Ste/Apt**

\_\_\_\_\_  
**Address** **Ste/Apt**

\_\_\_\_\_  
**City, State** **ZIP**

\_\_\_\_\_  
**City, State** **ZIP**

Please indicate method to receive records: **Pick up** \_\_\_\_\_ **Mail** \_\_\_\_\_ **Fax #** \_\_\_\_\_

**Reason for Request:** \_\_\_\_\_

Please select the information that may be used/disclosed, and the dates of such information:

- Entire Record
- Progress Notes
- Lab Results
- Other: \_\_\_\_\_
- Correspondence from other healthcare provider
- Immunization Records
- X-Ray Results

**Date Range From:** \_\_\_\_\_ **Date Range To:** \_\_\_\_\_

**Disclosure for Release of Information**

- I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.
- I understand that Little Rock Children's Clinic, P.A. may be paid for the costs of copying the information to be released.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used/disclosed under this authorization.
- I understand that I may revoke this authorization in writing at any time by delivering a copy of my revocation to Little Rock Children's Clinic, P.A. except to the extent that action has been taken in reliance on this authorization. This authorization expires ninety (90) days from the date it is signed below.

\_\_\_\_\_  
**Signature of Patient or Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Name of Personal Representative (if applicable)**

\_\_\_\_\_  
**Relationship to Patient**

\_\_\_\_\_  
**Witness**

\_\_\_\_\_  
**Date**