500 S. University Ave, Suite 615
Little Rock, AR 72205
Telephone: 501-664-4044 Fax: 501-664-4064

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I authorize the use/disclosure of my health information as described below:

Who is authorized to use/disclose the information?	□ **LRPC** Little Rock Pediatric Clinic 500 S. University, Suite 400 Little Rock, AR 72205	□ Other (address)
Who is authorized to receive the information?	□ **LRPC** Little Rock Pediatric Clinic 500 S. University, Suite 400 Little Rock, AR 72205	□ Other (address)
Description of information that may be used/disclosed.	□ Shot Record **ONLY** □ MD Notes (Date Range) _____ □ Lab Results (Date Range) _____ □ **Complete Record** □ Other _____	
The information will be used/disclosed for the following purposes:	□ Daycare Registration □ School Registration □ Athletics Registration □ Transferring Care to Another Primary Care Physician □ Relocating to Another City □ Other _____	

- 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 re-disclosed and no longer protected by these regulations.
- I understand that the Little Rock Pediatric Clinic will 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 copy 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 Pediatric Clinic 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 _____

Patient's Name _____ DOB _____

Name of Personal Representative (if applicable) _____

Relationship to Parent _____

Witness _____ Date _____

For office use only

Received in Medical Records (date) _____ by (name) _____
Copied Records identified in #3 (date/initials) _____
Mailed/Prepared for pt. pick-up (date initials) _____