Arkansas Pediatric Clinic, PLLC
Doctors Building 500 S. University Ave Suite 200
Little Rock, AR 72205
Office: 501-664-4117 Fax: 501-664-1137

Medical records email address: medicalrecords@arped.org

AUTHORIZATION TO RELEASE HEALTH INFORMATION

ALL ELEMENTS ARE REQUIRED PRIOR TO INFORMATION BEING RELEASED

Patient Name: _____ **Date of Birth:** _____

1. Who is authorized to disclose the information? **Arkansas Pediatric Clinic**
2. Who is authorized to receive the information? **Name:** _____

   Complete Address: _____

   Email Address: _____
3. The specific information to be requested or released is:
   List dates of service: _____

   ☐ All Medical Records ☐ Physical
   ☐ Clinic Visit Notes ☐ Shot Record
   ☐ Lab ☐ Other: _____
4. The information is needed for:

   ☐ Camp ☐ Continuity of Care
   ☐ School/Daycare ☐ Legal Reasons
   ☐ Insurance ☐ Other: _____
5. 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 disclosed and no longer protected by these regulations.
6. I understand that Arkansas Pediatric Clinic will be paid for the costs of copying the information to be released.
7. 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.
8. I understand that I may revoke this authorization in writing at any time by delivering a copy of my revocation to Arkansas Pediatric Clinic except to the extent that action has been taken in reliance on this authorization. This authorization expires: **One year from date signed.**
9. I understand Arkansas Pediatric Clinic will release the requested information only to the entity listed above.
10. I understand that I may receive personal health information via email and I understand that the email containing the requested information is unencrypted.

PLEASE PRESENT A COPY OF A PHOTO ID

_____ _____
Signature of Patient or Representative Date

_____ _____
Phone Number Relationship to Patient

_____ _____
Witness Date