ALL FOR KIDS PEDIATRIC CLINIC
AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Patient Name: _____Date of Birth:_____

Address on record:_____SSN:_____

I voluntarily authorize this clinic to release the protected healthcare information ("PHI") of the person above to:

Person/Company providing the information:
ALL FOR KIDS PEDIATRIC CLINIC
Fax number: 501-224-3473

Persons/Companies Receiving the information:
_____
_____
_____

Specific information to be released, with dates: _____

Purpose: a. If requested by the Patient/Patient's Personal Representative: ☐ At the request of the individual.
b. Other: [Must complete] _____
_____

Section A. Must be completed if health plan insurer or health care provider has requested the information.

1. a. The purpose of this disclosure is _____

   b. This disclosure will result in direct or indirect payment to the physician: YES _____ NO _____

2. The patient or personal representative must read and initial:
   a. I understand that my health care/treatment and the payment for my healthcare will not be affected if I do not sign this form.
   Initials: _____
   b. I understand that I may see and copy the information described on this form, if I ask for it, and that I get a copy of this signed form.
   Initials: _____

Section B. Must be completed for all authorizations.

The patient or the patient's personal representative must read and initial the following:

1. I understand that this authorization will expire on _____/ _____/ _____ or when the following event occurs:
   _____. Initials: _____
2. I understand that I have the right to revoke this Authorization at any time by notifying the clinic in writing, but it won't affect the actions taken before the clinic received the revocation. I understand that my personal representative or I must sign and date the letter of revocation.
   Initials: _____
3. Once this clinic gives out this information I want released, I know that the clinic has no control over the information. The person or company authorized to receive the information might re-disclose it without my knowledge or approval. Federal and state laws would no longer protect the information. Initials: _____.
4. I understand that treatment, payment, enrollment and benefits may not be conditioned upon my signing this Authorization.
   Initials: _____

I am aware that Healthport scans these records and mails to whom I have requested and that I will receive a bill for their service.
All of the information on this sheet much be completed before the clinic is released to these records sent.

_____ _____
Patient Signature/Patient's Personal Representative Date

If Personal Representative, explain the relationship or authority to act for the patient:

_____