GENERAL AUTHORIZATION

I hereby give my authorization for Arkansas Pediatrics of Conway, P.A. to use or disclose my Protected Health Information to carry out treatment, payment, or any other health care operations. I understand that my Protected Health Information is as follows:

> *Information that is oral or recorded in any form that relates to my past ,present, or future, physical or mental health condition, my past, present, or future health care treatment, or the payment of my past, present, or future health care treatment, that is or could reasonably identify me and is transmitted in an electronic form or maintained in any form.*

This Protected Health Information could include information that this Health Care Provider created, received from me, received from another Health Care Provider, received from a Health Plan, Health Care Clearing House, Insurance Company, Employer, or any other source, and could include demographic information about me.

I specifically give this Health Care Provider authorization to use or disclose my Protected Health Information to the following persons for the following purposes:

Which Records (check appropriate box):

- ❑ Shot record only
- ❑ Last visit only
- ❑ _____ (date) visit only
- ❑ All records
- ❑ Other (please specify) _____

Please Transfer Records To:

- ❑ Arkansas Pediatrics of Conway
  PO Box 1210
  Conway, AR 72033
  329-1800
- ❑ Other (daycare, school, etc.):
  _____(name)
  _____(address)
  _____(city,state,zip)
  _____(phone)
  _____(fax- shot records only)

From:

_____(name)
_____(address)
_____(city,state,zip)
_____(phone)

I understand that I have the right to revoke my authorization, however, it shall not be considered revoked to the extent my Health Care Provider has relied on it. I understand that once this information has been disclosed to third parties, there may not be any safeguards to prevent the third party from further disclosing the Protected Health Information. I request this authorization expire on the following date (complete date or circle): **_____, 20___** or **I request that this authorization expire when the child reaches the age of majority**. I may revoke it sooner in writing by contacting the Privacy Official, Donna Strickland, I may also reach her by phone at 329-1800. I understand the Health Care Provider cannot condition my treatment or evaluation on my signing this authorization.

_____ _____
Patient – Printed Name Patient – Signature (if age 18 or older)

_____
Patient's Date of Birth

_____ _____
Parent/Guardian of Patient Today's Date