

**Little Rock Family Practice Clinic**  
**AUTHORIZATION TO RELEASE AND/OR RECEIVE RECORDS**

Patient Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_

I hereby authorize \_\_\_\_\_ Clinic to:

- release copies of billing or medical records to the following persons or entities  
 receive copies of billing or medical records from the following persons or entities

The following information shall be obtained and/or released pursuant to this Authorization:

<input type="checkbox"/> History and Physical	<input type="checkbox"/> Operative Report
<input type="checkbox"/> Pathology Report	<input type="checkbox"/> Radiology Report
<input type="checkbox"/> Billing Records	<input type="checkbox"/> Other (Specify):
<input type="checkbox"/> Entire Designated Record Set	

Information may be released in writing, verbally, or by video, fax, photocopy, or microfilm.

**I request that the above information be released for the following date(s) of service:**

**NOTICE TO PATIENT/PATIENT REPRESENTATIVE:** If the recipient of the information disclosed pursuant to this Authorization is not a health care provider, health plan or health care clearinghouse, the information may be subject to redisclosure by the recipient and may no longer be protected by federal privacy laws and regulations.

The information will be obtained and/or disclosed for the following reason(s):

<input type="checkbox"/> Treatment/Continuity of Treatment	<input type="checkbox"/> Legal Reasons
<input type="checkbox"/> AT THE REQUEST OF THE INDIVIDUAL	<input type="checkbox"/> Assessment & Evaluation
<input type="checkbox"/> Other (Specify):	

This authorization will expire:  1 year from the date of the signature below,  
 Or  other: \_\_\_\_\_

This Authorization may be revoked by notifying our Privacy Officer in writing at the following address:

Jeff Erwin or Donna Finney, AFCN Privacy Officer  
 Little Rock Family Practice Clinic – West  
 4208 N. Rodney Parham  
 Little Rock, AR 72212  
 Phone (501)228-7200 Fax (501-228-2285)

**Note:** Protected health information may already have been disclosed before the revocation is received. If so, the revocation will be effective only as of the date it is received by AFCN.

\_\_\_\_\_  
 Patient Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Personal Representative's Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Personal Representative's Relationship/Authority

**This Authorization is voluntary.** A refusal to sign will **not** affect the patient's ability to obtain treatment, payment, or, if applicable, enrollment in a health plan or eligibility for benefits.