North Little Rock Primary Care Clinics, P.A.

Authorization for Release of Information

1. I hereby authorize: _____
_____
_____

2. To release my records to: North Little Rock Primary Care Clinics, P.A.
400 West Pershing Blvd
North Little Rock, Arkansas 72114
Phone: (501) 771-7717or Fax (501) 771-0550

_____ _____
Patient Name Date of Birth

Information to be released:

_____ Initial Examination
_____ Follow Up Care/Progress Notes
_____ Special Procedure Results
_____ Discharge Date
_____ Office Visit Notes (Date)
_____ Other _____

3. The above information is released for the following purpose and that purpose only. Any other use is forbidden:

4. I also understand that I may revoke this authorization at any time, except to the extent that action has been taken in reliance on it (e.g., probation, parole, etc.); and that in any event this authorization expires automatically as described above.

5. This authorization will expire twelve (12) months from the date of my signature or as otherwise specified by date, event or condition as follows:
_____
_____

6. With respect to any mental health information that may be contained in the patient's medical records, I hereby waive my/his/her rights to the privileges of confidentiality.

_____ _____
Signature of Patient or Authorized Legal Representation
Date

_____ _____
Relationship of Patient
Witness Signature

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