Ark-La-Tex Children's Clinic

2400 Hospital Drive, Suite 120
Bossier City, Louisiana 71111
(318) 742-6710
(318) 747-5393 (Fax)

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT NAME _____ **PREVIOUS NAMES, IF APPLICABLE** _____

DATE OF BIRTH _____ **DAYTIME TELEPHONE NUMBER** _____

SEND INFORMATION TO:

NAME: _____

ADDRESS: _____

_____

PHONE #: _____ **Fax #:** _____

PURPOSE OF DISCLOSURE: ☐ **Transfer of Care** ☐ **Self** ☐ **Specialist** ☐ **Other**_____
(MUST COMPLETE)

INFORMATION TO BE DISCLOSED:

☐ Medical Records from last two years
☐ Summary Health Information
☐ Complete Designated Record Set
☐ Other_____

Date(s) of Service:_____

Expiration Date (or event)_____

RELEASE OF INFORMATION FROM:

ARK-LA-TEX CHILDREN'S CLINIC
2400 Hospital Drive, Suite 120
Bossier City, LA 71111
(318) 742-6710
(318) 747-5393 (Fax)

If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient. This form must be dated within 90 days of receipt, and may be revoked at any time, providing the information has not already been disclosed. Please see our Notice of Privacy Practice for instructions as to how to revoke this authorization. We will not condition treatment on the completion of the authorization. Also, please be aware that once we disclose this information per your instructions the information is subject to re-disclosure and may no longer be protected by the HIPAA of 1996.

DATE _____ **SIGNATURE OF PATIENT OR LEGAL GUARDIAN** _____ **RELATIONSHIP TO PATIENT** _____

FOR VERBAL CONSENT, 2 STAFF MEMBERS MUST WITNESS & SIGN BELOW:

*WITNESS #1: NAME:*_____ *SIGNATURE:*_____ *TITLE:*_____

*WITNESS #2: NAME:*_____ *SIGNATURE:*_____ *TITLE:*_____

For Facility Use:

DATE RECEIVED:_____ **DATE INFORMATION RELEASED:**_____ **PERSON SENDING RECORDS:**_____