SPECIFIC AUTHORIZATION

I hereby give my authorization for Arkansas Pediatrics of Conway 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:

Name	Address	Phone Number	Purpose

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: _____,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 501-329-1800. 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