Little Rock Diagnostic Clinic, P.A.
Authorization for Use or Disclosure of Protected Health Information

I**,** (*Patient name*)**_____,** hereby authorize the Little Rock Diagnostic Clinic ("*the Provider*") to use or disclose the following protected health information:

- ☐ **All health and financial information.**
- ☐ **Health information only.**
- ☐ **Financial information only.**

The protected health information may be disclosed to: _____

Relationship:_____

This protected health information is being used or disclosed for the following purposes:

To discuss and disclose the information with the party listed above.

This authorization shall be in force and effect until the patient rescinds the authorization.

I understand that, as set forth in the provider's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to: Little Rock Diagnostic Clinic, Attn: Privacy Officer, 10001 Lile Drive, Little Rock, Arkansas 72205

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of Patient or Personal Representative Physician

_____ _____
Description of Personal Representative's Authority LRDC #