

Little Rock Diagnostic Clinic, P.A.
Authorization To Release Copies of Health Information

I, (*Patient name*) _____ hereby authorize _____
 (“*the Provider*”) to use or disclose the following protected health information:

The protected health information may be disclosed to:

Name and
Address _____

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

- At the patients request Other _____

This authorization shall be in force and effect until (date) _____ or the happening of the
following expiration event:

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 redisclosure by the recipient and may no longer be protected by federal or state law. I understand that the provider will not condition my treatment on whether I provide authorization for the requested use or disclosure. 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 of Birth Date

Name of Patient or Personal Representative Description of Representative

LRDC # Physician