The Children's Clinic of Jonesboro, P.A.
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Authorization for Release of Confidential Information

Please list name, address & phone #

FROM / TO (circle one)

The Children's Clinic
800 S. Church, Suite 400
Jonesboro, AR 72401
Phone: 870-935-6012
Fax: 870-934-3157

TO / FROM (circle one)

____

____

____

____

Contact Person: ______________________________

Contact Person: ______________________________

I, ____ the patient or parent /guardian of the patient named below, give The Children's Clinic permission to obtain from or give to the above named agency/person pertinent, social, medical, or other information as listed below. I understand that this information is confidential and will only be used for the benefit of this patient. I understand that this information may be subject to re-release by the recipient without the knowledge or consent of The Children's Clinic and that The Children's Clinic is in no way responsible for this action. I further understand that this consent form is considered valid for ONE YEAR or for the duration of this patient's treatment, whichever is shortest, and that I may revoke this release at any time by requesting it in writing and submitting it to this office.

Notice: The Children's Clinic may not condition services upon signing this form unless the services are being provided for a third party.

Documents to be released (must list each specifically):

1.____

2.____

3.____

Purpose for release:

________ At the request of the patient or parent/guardian ____________________

________ Other: ____

Patient's Name____DOB:_________________Chart #:________________

Signature of Patient or Parent/Guardian____Date:__________________
(REQUIRED) (REQUIRED)