The Children’s Clinic of Jonesboro, 800 South Church, Suite 400, Jonesboro, AR 72401  
Phone: 870-935-6012 Fax: 870-934-3157  
Charles Kemp, M.D. Jane Sneed, M.D. Kevin Rouse, M.D. Angela Edwards, M.D. Gregory Buxton, M.D.  
Stephen Ashodian, M.D. Adam Hurst, M.D. Kellie Cox, APRN Kristen Luce, APRN  
Shay Crook, APRN Molly Johnson, APRN Jill Davis, APRN

**Authorization for Release of Confidential Information**

FROM / TO: The Children’s Clinic of Jonesboro, 800 South Church, Suite 400, Jonesboro, AR 72401  
(circle one) Phone: 870-935-6012 Fax: 870-934-3157

TO / FROM: Name/Clinic:

Address:

City/State/Zip:

Phone: Fax:

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 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.

Purpose for release   
 (REQUIRED)

Patient’s Name DOB:

Signature of Patient, Parent, Guardian Date:   
 (REQUIRED) (REQUIRED)

Relationship to patient   
 (REQUIRED)