GENERAL AUTHORIZATION

I hereby give my authorization for TLC Pediatrics, PLLC 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:

Which Records (check appropriate box):

- ❑ Shot record only
- ❑ Last visit only
- ❑ _____(date) visit only
- ❑ All records

Please Transfer Records To:

- ❑ TLC Pediatrics, PLLC
  605 Salem Rd., Suite B2
  Conway, AR 72034
  501-327-2444
  501-327-2443 (fax)

From:

_____(Clinic Name)
_____(Address)
_____(City, State, Zip)
_____(Phone)

- ❑ Other (daycare, school, etc.):

_____ (Name)
_____ (Address)
_____ (City, State, Zip)
_____ (Phone)
_____ (Fax-shot records only)

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 (complete date or circle): _____, 20___ or **I request that this authorization never expire.** I may revoke it sooner in writing by contacting the Privacy Official Lindsey Dill. I may also reach her by phone at 501-327-2444. I understand the Health Care Provider can 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 Signature

_____
Date