AUTHORIZATION TO DISCLOSE
PROTECTED HEALTH CARE INFORMATION
FOR

____
Child's name

DOB: ___________________

I, _________________________(parent or guardian), do hereby authorize all providers and entities that may be or that have been providing medical, psychological or other care protected under the Health Insurance Portability and Accountability Act (HIPAA) to my child, _________________________, to disclose protected health information to CAROL D. NOKES, ATTORNEY AD LITEM, P.O. Box 21208, LITTLE ROCK, AR 72221, (501) 223-9620 at her request.

Information disclosed pursuant to this authorization is subject to re-disclosure and may no longer be protected by the privacy rules of 45 CFR §164.

I understand that this authorization may be revoked in a writing signed by me. I further understand that I must present my revocation of this release to the facility from which protected information is to be released in order for the revocation to be effective. This release will automatically be revoked upon the final hearing or dismissal of ____________________________*v.*__________________________, _____DR-20___-_____, _____________County Circuit Court, Arkansas.

EXECUTED this _______ day of ______________20____.

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Signature of parent or guardian