BATESVILLE THERAPY CLINIC, INC.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Batesville Therapy Clinic, Inc. to use and disclosed protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

Batesville Therapy Clinic, Inc.'s Notice of Privacy Practices provides a more completed description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

Batesville Therapy Clinic, Inc. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Batesville Therapy Clinic, Inc. Attn: Tammy Pearce 1310 Sidney Street Batesville, AR 72501 (870) 612-7200.

With this consent, Batesville Therapy Clinic, Inc. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Batesville Therapy Clinic, Inc. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Batesville Therapy Clinic Inc. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders cards and patient statements. I have the right to request that Batesville Therapy Clinic, Inc. restrict how it uses or disclosed my PHI to carry out TPO. However the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Batesville Therapy Clinic Inc.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Batesville Therapy Clinic, Inc. may decline to provide treatment to me.

_____	_____
Patient's Name	**Print Name of Legal Guardian**
_____	_____
Signature of Patient	**Signature of Legal Guardian**
_____	_____
Date	**Witness**