BATESVILLE THERAPY CLINIC, INC.
1310 SIDNEY STREET
BATESVILLE, AR 72501

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

The undersigned hereby authorizes _____
To release certain medical record information as specified below:

Patient's name _____

Patient's Address_____

Patient's date of birth_____

Period of Hospitalization involved:_____

Person or Organization to whom the medical record information is released:
_____
_____

Portion of medical record to be released:
_____ Patient identification data
_____ History & Physical
_____ Consultation reports
_____Diagnostic and therapeutic orders
_____ Physican's progress note
_____ Reports of operations, procedures, tests and their results
_____ Discharge summary
_____ Emergency Dept. reports
_____Prior Authorizations for release of medical record information and actions thereon
_____Entire medical record
The purpose or need for this disclosure is:_____
_____

This authorization is subject to revocation at any time. Without prior revocation, this authorization will automatically expire ninety (90) days from this date. The party signing this authorization has a right to receive a copy of it.

_____ _____/_____/_____
Signature of Patient or Legal Representative Date of Authorization

_____
Print Name

If this authorization is signed by anyone **other** than the patient concerned, the basis of this signer's authority is:_____
_____