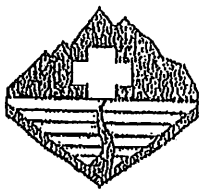

MOUNTAIN HOME CHRISTIAN CLINIC

421 WEST WADE AVENUE MOUNTAIN HOME ARKANSAS 72653 / PHONE (870)425-5010 / FAX (870)424-2442

MEDICAL RECORDS RELEASE

Patient Name: _____ DOB: _____ SSN: _____

Party #1: Mountain Home Christian Clinic
421 W. Wade Avenue
Mountain Home AR 72653

Party #2 _____ ATTN: _____
Agency from whom requesting patient records

Address: _____
State: _____ Zip Code: _____ Fax #: _____

Type, Purpose, and Content

[ ]Release of records from another agency to Mountain Home Christian Clinic

[ ] Release of records from Mountain Home Christian Clinic to another agency

Purpose of release: (Specify- must be completed by the patient or authorized representative):

_____

_____

I hereby authorize the release of the following information:

_____

_____

_____

I understand that general medical/psychiatric records sometimes contain references to drug/alcohol use, communicable or sexually transmitted diseases, as well as AIDS and HIV test results. Please initial _____.

I understand that I may revoke this consent at any time except to the extent action has been taken on it, and that in any event this expires within 90 days of signature or with the following date, event or condition:

Date: _____ Signature of Patient: _____

Witness: _____ Authorized Representative: _____