THE ARK
Children's Clinic

924 State Highway 77 Marion, AR 72364 Phone: 870-551-2626 Fax: 870-739-876

MEDICAL RECORDS RELEASE

I, _____,do hereby authorize

_____ Phone#_____ Fax#_____

to release to The Ark Children's Clinic. The complete history in your possession concerning my illness and/or treatment during the period from:
_____ to _____.

Include the following specific type data (check all that apply):

____Discharge Summary ____Radiology Reports _____Labs ____E.D. Note

___History & Physical ___ Outpatient Clinic Records ____Operative Report

___Entire Medical Record ___Other:_____.

* If no expiration date or period is known it will expire six (6) months after the date recorded below.

* I further understand that any disclosure of records concerning diagnosis and/or treatment for alcohol or drug abuse is covered by Title 42 of the Code of Federal Regulations, and if there is any such information, I hereby authorize the release of this information.

* This authorization also includes any information related to diagnosis and/or treatment of any genetic condition, psychiatric or mental illness and/or any state of infection with the HIV (AIDS) virus.

Name:_____ Date of Birth:_____

Signature:_____Date:_____

Relationship to Patient:_____

The Ark Children's Clinic Witness:_____

If you receive this fax in error please notify the office and discard. Thank you!