

**Arkansas State University-Newport
Catastrophic Leave Bank Program
(Authorized by Act 160 of 1991)**

RECORD RELEASE

I hereby authorize and request that you release the complete medical records in your possession concerning my illness and/or treatment to:

**Arkansas State University-Newport
Catastrophic Leave Bank Committee
Attn: Bettye Davis
7648 Victory Blvd
Newport, AR 72112
Phone: 870-512-7874
FAX: 870-512-7807**

Patient's
Name _____

Illness/Condition: _____

Patient's Signature: _____

Date: _____

If Catastrophic Leave is requested for a dependant, please complete the following:

Employee's Name: _____

The above information is confidential and should be treated as such. Please deliver to Bettye Davis, Human Resources, immediately.