705 W Oakland Ave Broken Arrow, Ok 74012 Phone 918-251-2666 Fax 918-258-7790

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:______________________________ **Date of Birth:**______________________

Address: ______________________________ City/State/Zip: ______________________

Phone Number:______________________________

Please Note: Copy Fee May Be Charged for Medical Records; $1.00 for first page and 0.50 for each page there after

Above listed patient authorizes the following healthcare to make record disclosure: ***(Facility that is to release the Medical Records)***

Facility Name______________________________ FacilityPhone______________________

Facility Address______________________________ Facility Fax______________________

Dates and type of information to disclose:

☐ Entire Record ☐ Immunization(shot)Record ☐ 2 years prior to last visit ☐ Specific date______________

RETRICTIONS: only medical records originated through the healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to including the date on this authorization unless other dates are specified. I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse. There is up to 30 days the facility has to send out the medical records from the date received to their facility.

This information may be disclosed and used by the following: ***(Facility or individual that is to receive the Medical Records)***

Name______________________________ Phone______________________

Address______________________________ Fax______________________

☐ Please Fax Records (if less than 30 pgs.) ☐ Please Mail Records

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy. **This authorization will expire 1 year from the date signed.** I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have any questions about this disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do herby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

______________________________ ______________________

Signature of Patient/Parent/Guardian or Authorized Representative **Date**

Printed name______________________________ **Relationship to patient**______________________