



**Authorization to Release and Disclose Patient Information**

<b>PATIENT INFORMATION</b>	Name: _____ Date of Birth: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____
<b>Clinic/Hospital/Health Care Provider</b> <i>(Who has the information you want released?) Please list the specific Hospital and/or clinic</i>	Name: _____ Date of Birth: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____ Fax: _____
<b>Receiving Party</b> <i>(Where do you want the information sent? Who may receive the information?)</i>	Name: _____ Date of Birth: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____ Fax: _____
<b>Information to be Released</b> <i>What do you want sent or released? Check the appropriate box</i>	Only records types checked below: <input type="checkbox"/> Discharge Summary/Note <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Medication Records <input type="checkbox"/> History & Physical Exam <input type="checkbox"/> Immunization/allergy record <input type="checkbox"/> Operative Report <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Progress Notes/Clinic Notes <input type="checkbox"/> Pathology Reports <input type="checkbox"/> Other records specify record type(s) _____ <input type="checkbox"/> All records Date(s) of service: _____
	<b>Items in this box will be released unless checked:</b> <input type="checkbox"/> Physician's Psychiatric Diagnoses <input type="checkbox"/> Alcohol and Drug Info/Treatment <input type="checkbox"/> AIDS/HIV/STD Testing and Results
<b>Purpose of Release</b>	<input type="checkbox"/> Continuing Care <input type="checkbox"/> Transfer of Care <input type="checkbox"/> Social security appeal <input type="checkbox"/> Insurance application <input type="checkbox"/> Personal use or review <input type="checkbox"/> Social security disability determination <input type="checkbox"/> Insurance payment/claim <input type="checkbox"/> Litigation/Legal <input type="checkbox"/> Other
<ul style="list-style-type: none"> <li>• This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____</li> <li>• This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy</li> <li>• If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed</li> <li>• I understand that I may see and obtain a copy of the information described on this form for a reasonable copy fee, if I ask for it and I may refuse to sign this authorization (it is strictly voluntary)</li> <li>• I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information covered by this authorization. The entity authorized to disclose the information will not be compensated by the recipient for the disclosure, except for the cost of copying and mailing as authorized by law. I will receive a copy of this form after I sign it. Per 76 Okla Stat 19 Access to Medical Records</li> <li>• <b>"The information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease."</b></li> </ul>	

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 Patient/Legal Guardian Signature                      Date                      Authority to act on behalf of patient (attach document)