Lawton Community Health Center

Authorization to Release and Disclose Patient Information

PATIENT INFORMATION	Name: _____ Date of Birth: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____
Clinic/Hospital/Health Care Provider – (*Who* has the information you want released?) Please list the specific Hospital and/or clinic	Name: _____ Date of Birth: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____ Fax: _____
Receiving Party (***Where*** do you want the information sent? ***Who*** may receive the information?)	Name: _____ Date of Birth: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____ Fax: _____
Information to be Released *What* do you want sent or released? Check the appropriate box	**Only records types checked below:** **___ Discharge Summary/Note** **___ Radiology Reports** **___ Medication Records** **___ History & Physical Exam** **___ Immunization/allergy record** **___ Operative Report** **___ Laboratory Reports** **___ Progress Notes/Clinic Notes** **___ Pathology Reports** **___ Other records specify record type(s) _____** **___ All records** **Date(s) of service: _____**
	Items in this box will be released unless checked: ○ Physician's Psychiatric Diagnoses ○ Alcohol and Drug Info/Treatment ○ AIDS/HIV/STD Testing and Results
Purpose of Release	**___ Continuing Care** **___ Transfer of Care** **___ Social security appeal** **___ Insurance application** **___ Personal use or review** **___ Social security disability determination** **___ Insurance payment/claim** **___ Litigation/Legal** **___ Other**

- This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____
- 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
- If the requestor or receiver is not a health plan or health care provider, the released information my no longer be protected by federal privacy regulations and may be re-disclosed
- 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)
- 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
- **"The information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease."**

_____ _____ _____

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