AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient Name:____Date:______________

Address: ____

City: _______________________ State: ____________________ Zip Code: _______________

Date of Birth: ________________________________

I hereby authorize _____________________________ to release photocopies of my medical records into

my own keeping or to the following individual or organization ____________________________________.

Information to be released: ____

Please mail to: ____

Address City State Zip Code

Please fax to: _____________________________ Call to pick up: _________________________________

Phone Number

The facility, its employees and officers and the attending physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized by this release. I understand this consent can be revoked at any time except for any disclosure already made in good faith, in reliance on this release. I realize by the receipt or authorized release of these records that I am accepting responsibility or the protection of my own right of medical confidentiality.

I acknowledge that the law of the state of Oklahoma provides the following:

The information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

SIGNATURE OF PATIENT / PERSON AUTHORIZED TO SIGN OTHER THAN PATIENT

SIGNATURE: ____________________________________ **DATE:** ______________________________

RECORDS COPIED: ________________________ RECORDS FEE: __________________________

PICKED UP: ______________________________ RELEASED BY: __________________________