AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

owasso pediatric & adolescent medicine

Patient Information:

_____ _____ _____

PRINT Patient Name In Full | Date of Birth | Social Security #

I hereby authorize Owasso Pediatric and Adolescent Medicine ("Provider) and its agents and employees to ___ **release** or ___ **obtain** (please check the appropriate space) information and copies or records pertaining to my medical care and treatment which could include information about communicable or venereal disease, mental health, or drug, substance or alcohol abuse.

Release to:

_____

Name of designated Facility or Provider

_____

Address

_____

City, State, Zip Code | Phone Number

Obtain from:

_____

Name of designated Facility or Provider

_____

Address

_____

City, State, Zip Code | Phone Number

Information to be Released:

___ All medical records
___ The most recent two years of pertinent information (chart notes, labs, x-rays, and special tests)
___ Specific information (please specify):_____

Purpose for which request is being made (please check one of the following):

___ Physician ___ Medical Claims Processing ___ Self ___Attorney ___Other_____

I understand that if I am requesting records/information for release to me or a patient representative:

- laws may prevent certain records being released to the patient
- in certain situations, records denied for release to the patient may allow patient to request and obtain a review of the denial

Drug/Alcohol Abuse Treatment Records: This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I, the undersigned, hereby authorize the release of my (or give relationship) _____ medical record as specified above. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug related conditions, alcoholism and/or psychiatric/psychological conditions to the above mentioned entity (s).

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR NONCOMMUNICABLE DISEASE.

My Rights:

I understand that I do not have to sign this authorization in order to obtain health care benefits. I may revoke this authorization in writing by following the process described in the Notice of Privacy Practices posted in this office. I understand that Provider has no control over any information and records released to any other person, firm or agency under this Authorization and it is, therefore, possible that a release of this information or records may occur by such other party.

Reasonable Fee:

State law provides that a health care provider may charge a reasonable fee.

I release Provider, its employees and agents from any liability in connections with the use or disclosure of the information and records released to any party pursuant to this Authorization.

_____ _____ _____

Signature of Patient or Patient's Authorized Representative | Date | Time

_____ _____

Reason Patient Unable to Sign | Relationship to Patient

This Authorization will expire in twelve (12) months or _____.