MEDICAL RECORDS RELEASE AUTHORIZATION

South Tulsa Pediatrics

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Patient's Name(s): _____ Date(s) of Birth: _____
_____ _____
_____ _____
Patient's Address: _____
City _____ State _____ Zip Code _____
Patient's Phone #: _____

Date Range Needed: (Example: All or 1/1/17 to Present) _____

Information to be disclosed (check all applicable items to be released):

___ Office Visit Notes
___ Immunization Records
___ Medication Records
___ Specific Records/Other (Please Specify) _____
___ Well Child Exams
___ Lab/Radiology Reports

Purpose of disclosure: ___ Continued Medical care ___ Insurance ___ Legal ___ Patient's Own Use
___ Other: _____

___ **I am requesting my South Tulsa Pediatrics records to be sent to:**
Physician/Clinic Name: _____
Address: _____
City, State, Zip Code: _____
Phone: _____ Fax: _____

___ **I am requesting my previous records to be obtained from:**
Physician/Clinic Name: _____
Address: _____
City, State, Zip Code: _____
Phone: _____ Fax: _____

___ **I am requesting these records into my own keeping.** I understand and agree that there may be costs associated with this request in compliance with State copying laws. Currently, the costs are $1.00 for the first page and fifty (50) cents for each additional page and the actual cost of postage if the record is to be mailed.

I further release the entities listed above, their agents and employees from liability in connection with the use and disclosure of the protected health information covered by this authorization. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by Federal law.

This authorization expires on: _____ (date). If no date is specified, this authorization will expire 12 months from the date of signature. I have the right to withdraw permission for the release of my information and such revocation must be made in writing and will not affect information that has already been used or disclosed.

According to Oklahoma State law you must be advised**: The information authorized for release may include records which indicate the presence of a communicable or non-communicable disease. I further understand that medical information may indicate that the patient has or has been treated for psychological or psychiatric conditions or substance abuse.**

I realize by the release and/or receipt of these records that I am accepting responsibility for the protection of my own right of medical record confidentiality.

_____ _____
Signature of Patient/Person Authorized to Sign for Patient Date

_____ _____
Printed Name Relationship to patient