

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(Copies will be provided at \$0.50 cents per page. Radiology film copies will be provided at \$5.00 per sheet. Plus applicable postage and handling)

Office Use Only

DATE RECEIVED: _____ **DATE RELEASED:** _____

Patient Name: _____ Date of Birth: _____ Social Security #: _____

Phone Number: _____ Secondary Phone Number: _____

Purpose of disclosure: ___ Patient's request ___ Dispute ___ Treatment ___ Other: _____

Date(s) of Records Requested: _____ to _____

I am the: ___ Patient ___ Guardian ___ Parent ___ Other ___ Continuation of care

Would you like to receive the requested records in an electronic format? Yes ___ No ___

ONLY COMPLETE IF YOU THE PATIENT ARE NOT RECEIVING THE RECORDS AND THEY ARE BEING FORWARDED TO SOMEONE ELSE.

I hereby authorize Oklahoma Heart Hospital Physicians personnel to disclose medical information on the above named patient to: i.e attorneys name, physician, child, etc.

Please Circle or Complete Below: SELF OTHER: _____

Must Provide Name of Person Receiving Records _____

Below is the address of where to mail the medical records.

Address: _____

City: _____ State: _____ Zip Code: _____ Fax #: _____

I would like the following information:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Face Sheet | <input type="checkbox"/> Emergency Room Report | <input type="checkbox"/> EEG Report(s) | <input type="checkbox"/> History and Physical |
| <input type="checkbox"/> Operation Report(s) | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Consultation Report(s) | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Physician's Orders | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> EKG Report(s) | <input type="checkbox"/> Radiology CD |
| <input type="checkbox"/> Laboratory Reports(s) | <input type="checkbox"/> Radiology Report(s) | | |
| <input type="checkbox"/> Other: _____ | | | |

I understand:

- I may revoke this authorization at any time, in writing. My revocation will not apply to information already retained, used or disclosed in response to this authorization. Unless revoked, the automatic expiration date will be six (6) months from the date of signature.
- Unless the purpose of this authorization is to determine payment of a claim or benefits, OHHP may not condition the provision of treatment or payment for my care on my signing this authorization.
- Information used or disclosed under this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.
- **THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NON COMMUNICABLE DISEASE.**
- The information authorized for release also may include protected health information related to mental health.
- The information authorized for release also may include 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. As a result, by signing below I specifically authorize any such records included in my health information to be released.

Signature of Patient, Parent, or Legally Authorized Representative _____ Relationship to Patient _____ Date _____
Patient must sign unless there is a Power of Attorney or if deceased it must be signed by the Executor of the Estate

Please Fax to: Oklahoma Heart Hospital Physicians
MEDICAL RECORDS DEPARTMENT
4050 W. Memorial Road
Oklahoma City, OK 73120
Fax to (405) 608-3838