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Authorization For The Release of Medical Records

Patient Name: ____Date: ___________________

Address: ______________________City:________________ State: ________ Zip__________

Telephone:__________________________ Date of Birth_______________________________

By signing below, I fully acknowledge and agree that I hereby authorize _______________________________ to release photocopies of my medical records into my own keeping, to the following listed individual or organization:

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The facility, it's 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 the 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 for the protection of my own right of medical records confidentiality.

I am aware and agree that I am financially responsible for the following fees associated with my request: copying charges, including cost of supplies and labor, and any postage to the production of my information. ***I understand that the charge for this service is $1.00 for the first page and $.50 per page after that.*** This money is due before records will be released.

I acknowledge that the law of the state of Oklahoma provides for 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 not limited to disease such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus also known as acquired immune deficiency syndrome (AIDS).

____ ________________________
Signature of Authorized Person/Patient Date

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If not the patient- how are you related