

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy rules.

Patient Name: _____ SS No. _____

Date of Birth: _____

_____ I am requesting my records to be sent to:

Physician or clinic: _____

Address: _____

City, State, Zip: _____

Fax: _____ Phone: _____

_____ I am leaving Broken Arrow Family Practice Center

_____ I am not leaving Broken Arrow Family Practice Center

The patient or patient's representative must read the following statements:

I understand that I may revoke this authorization at any time by notifying Broken Arrow Family Practice Center in writing. If I do, it will not have any affect on any actions taken prior to receiving the revocation. If this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer the right to contest a claim under the policy or the policy itself.

The information authorized for release may include records which may indicate the presence of a communicable or venereal disease or noncommunicable 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 and diabetes. I also understand that psychiatric (including depression) and/or chemical dependency conditions and/or medications for these conditions may be contained in my medical records and cannot be separated during the process of complying with my request for such information.

Signature of Patient or Patient's Representative

Date

Printed Names of Patient or Patient's Representative

Relationship to Patient