

McAlester Regional Health Center
One Clark Bass Blvd.
McAlester, Ok. 74501
(918) 426-1800



AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize _____
(Name of facility)

(Mailing address) (City) (State/Zip)

To release my information to _____
(Name of facility)

(Mailing address) (City) (State/Zip)

For the following purpose _____

REPORTS TO BE FURNISHED:

- Complete Medical Records
- Discharge Summary
- History and Physical
- Consultation
- X-Rays and EKG
- Operative/ Path Report
- Physician Orders
- Nurses Notes
- ER Report
- Other _____

I AUTHORIZE THIS RELEASE KNOWING AND UNDERSTANDING THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE ACCORDING TO THE OKLAHOMA STATE LAW.

THIS INFORMATION INCLUDES INFECTIOUS DISEASE AND SEXUALLY TRANSMITTED DISEASES SUCH AS HEPATITIS, TUBERCULOSIS, YELLOW FEVER, ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS), HIV INFECTION, SYPHILIS, GONORRHEA AND CHLAMYDIA.

I understand that my records are protected under the Federal and State Confidentiality regulations and cannot be released without my written consent. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains.

This consent shall expire automatically within 90 days or as specified: _____

I may revoke this consent at any time

A photocopy or facsimile copy of the original shall be treated as the same.

Patient's Full Name

Signature of patient

Date of birth or Social Security #

Date of Signature

Dates of Treatment

Signature of Guardian or Other

Witnessed by