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 health information to ______________________________
(Name of Facility)

____
(Mailing Address) (City) (State/Zip)

for the following purpose ______________________________

REPORTS TO BE FURNISHED

- ☐ Complete
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Consultation
- ☐ X-rays and EKG
- ☐ Operative/Path Report
- ☐ Physician Orders
- ☐ Nurses Notes
- ☐ ER Report
- ☐ Other: ______________________________

I AUTHORIZE THIS RELEASE KNOWING AND UNDERSTANDING THE RECORDS MAY CONTAIN INFORMATION RELATING TO A REPORTABLE COMMUNICABLE DISEASE WHICH IS CONFIDENTIAL ACCORDING TO 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 of as specified: ______________________________

I may revoke this consent at any time.

____
PATIENT'S FULL NAME

____
Signature of Patient

____
Date of Birth of Social Security #

____
Date of Signature

____
Date of Treatment

____
Signature of Guardian or Other

____
Witnessed by