McAlester Regional
HEALTH CENTER
Southeast Oklahoma's Leading Healthcare Resource

Patient Identification

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize McAlester Regional Health Center, One Clark Bass Blvd, McAlester, OK 74501 to release my health information to:

Name of Facility or Self:

Mailing Address:_____

For the following purposes:_____

REPORTS TO BE FURNISHED:

- ☐ Complete
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Consultation
- ☐ X-rays and EKG
- ☐ Operative Note
- ☐ Physician Orders
- ☐ Nurses Notes
- ☐ ER Report
- ☐ Other: _____

I AUTHORIZE THIS RELEASE KNOWING AND UNDERSTANDING THE RECORDS MAY CONTAIN INFORMATION RELATINS 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, GONORRHEAS AND CHLAMYDIA.

I understand that my records are protected under 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 the 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 Number

_____
Date of Signature

_____
Date of Treatment

_____
Signature of Guardian or Other