CONSENT/AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This form is to verify that I am the…

(initial one) ________ Patient (Skip Section B)
________ Parent of the below named patient.
________ Legal guardian of the below named patient
________ Legal custodian of the below named patient

405-219-2651 FAX#: 405-609-6679

Section B.
Parent – Legal Guardian/Custodian Information:

Name (please print):____

Date of Birth: ________________ **Sex:** M / F (circle one) **Relationship to patient:** ___________________________

Section C.
Patient Information

Patient Name: ____

Social Security #:____ **Date of Birth:** ___________________________________

I authorize the release of my/the above patient's medical records from your facility to:

FedCare at The Broadway Clinic
1801 N. Broadway Avenue
Oklahoma City, Oklahoma 73103
Phone: (405) 219-2651 Fax: (405) 609-6679

Treatment dates to be included in disclosure: (initial one)

________ ALL RECORDS

________Specific Dates/Tests: ____

Date, Event, or Condition when Consent Expires: ____
In the event no date, event, or condition is specified for expiration, this consent expires in one year from the date of signing.

In the event no date(s) of service are specified above, medical provider is authorized to release ALL of my medical records. This includes, but is not limited to, all medical records, itemized billing records, pharmacy records, patient information forms, radiology records, doctor's notes, nurse's notes, and other treatment records.

By signing below, I understand my rights under the provision of the Health Insurance Portability & Accountability Act (HIPPA) of 1996. I further understand that this authorization is voluntary and that I may refuse to sign it.

I understand that treatment of services is not contingent upon or influenced by my decision to permit the information release. I also understand that I may revoke this consent in writing at any time, unless action has already been taken based upon it. I freely and voluntarily give this consent.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law.

THE INFORMATION I AUTHORIZE FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND THE HUMAN IMMUNODEFICIENCY VIRUS (HIV), ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) OKLA..STAT.ANN.TIT. § 63 1-502.2(b)

Photocopies of this authorization shall carry the same authority as the original.

____ _____________________________
Signature of Patient, Parent, Legal Guardian/Custodian Date

____ _____________________________
Witness Date