AUTHORIZATION FOR RELEASE AND TRANSFER OF MEDICAL HEALTH RECORDS TO UTICA PEDIATRICS

Patient Information

Name: _____ Date of Birth: _____

Address: _____

The above listed patient authorizes the following healthcare facility to provide the record disclosure:

Facility Name: _____ Facility Phone: _____

Address: _____ Facility Fax: _____

City, State, Zip: _____

Dates and Information to Disclose:

____ Entire record ____ Vaccine Record

____ Two years prior from last date seen

____ Dates: _____

Purpose of Disclosure:

____ Change of Physician

____ Collaboration of Care

____ Referral

The specified medical health records are to be disclosed to the following facility:

Utica Pediatrics
1589 E 19th St
Tulsa, OK 74120
Ph: 918-743-8941 Fax: 918-744-4459

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire one year from the date above.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making the disclosure.

I understand the information in my health record may include information relating to sexually transmitted infections, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for substance use or abuse disorder.

I have read the above foregoing Authorization for Release and Transfer of Medical Health Records and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____

Signature of Patient/Parent/Legal Guardian/Authorized Representative Date

_____ _____

Printed Name Relationship to Patient