Authorization for Release of Medical Information

Patient name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

☐ I will pick up copies of my records ☐ Please fax or mail my records to the Physician/Facility listed below

☐ I authorize Pediatric Specialists of Tulsa to **release information to**:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #

☐ I authorize Pediatric Specialists of Tulsa to **obtain information from**:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #

Purpose for this request: (check one) ☐ Specialists ☐ Transfer of Care ☐ Personal ☐ Other _____

Requested Information:

☐ Entire Medical Record ☐ Immunization Records- ☐ Most recent Progress Notes
☐ X-Ray/Radiology Reports ☐ Billing Records ☐ Other _____
☐ Lab/Pathology Reports ☐ Mental Health Records (ADD/ADHD)

I hereby request access to the protected health information in my health record. I understand:

- I may revoke this authorization at any time by providing my written revocation to the address at the top of this form. My revocation will not apply to information already retained, used or disclosed in response to this authorization. Unless sooner revoked, the automatic expiration date of this authorization will be twelve (12) months from the date of signature.
- The information authorized for release may include records that may indicate the presence of a communicable disease or non-communicable disease and/or may indicate that I have been treated for a psycological or psychiatric condition(s).
- There may be a charge for the requested records, $1.00 for the first page and .50¢ for each additional page plus mailing costs. There will be charge for records sent to another physician and no charge for updated immunization records given at the time of vaccine administration.

_____ _____
Signature of Patient/Parent/Legal Guardian Date

_____
Relationship to Patient