



510 SE Delaware Ave. · Bartlesville, OK 74003
 (918) 331-2300 · FAX (918) 331-2399

Authorization for Release of Individually Identifiable Health Information

Patient Name		Contact Phone Number:
Birth Date:	Social Security Number:	Treatment Dates From: _____ To: _____

Person/Organization information is being RELEASED TO:		Person/Organization information is to be OBTAINED FROM:	
Name of person/organization/contact person		Name of person/organization/contact person	
Address		Address	
City, State, Zip		City, State, Zip	
Phone	Fax	Phone	Fax:

Specific description of information being released:

Billing Information (Financial/Insurance) Chart Notes Lab Reports
 Immunization Records X-Ray Reports and/or Copies Medication List
 Other (must specify) _____

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I UNDERSTAND:

- This may include records involving communicable or venereal disease, psychiatric, drug abuse and/or alcoholism. The information authorized for use or disclosure may include information, which may be considered a communicable, or venereal disease, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).
- This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.
- I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- Information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient or Personal Representative

Date

Printed name of Patient or Personal Representative

Relationship to Patient