PH|PRISTINE HEALTH
CARLEY MCLAUGHLIN, APRN-CNP
FAMILY NURSE PRACTITIONER
1709 W. 33RD STREET EDMOND, OK 73025
405-229-8209
PRISTINEHEALTHOK.COM

MEDICAL INFORMATION RELEASE CONSENT FORM

NAME _____ DOB _____ SSN _____

I, _____ (NAME), APPROVE THE BELOW COMPANIES OR INDIVIDUALS TO DISCLOSE MEDICAL INFORMATION ON THE PERSON NAMED ABOVE.

NAME/COMPANY	**ADDRESS**	**PHONE/FAX**

THE COMPLETE MEDICAL RECORD WILL BE RELEASED TO:
PRISTINE HEALTH
CARLEY MCLAUGHLIN, APRN-CNP
1709 W. 33RD STREET
EDMOND, OK 73025
405-229-8209

I ACKNOWLEDGE THAT MY HEALTH RECORDS MAY INCLUDE BUT ARE NOT LIMITED TO:

- SEXUALLY TRANSMITTED DISEASES INCLUDING AIDS/HIV _____ (INITIAL)
- MENTAL HEALTH _____ (INITIAL)
- DRUG/ALCOHOL USE _____ (INITIAL)

I ACKNOWLEDGE THAT:

- I MAY REVOKE THIS AUTHORIZATION WITH WRITTEN NOTICE _____ (INITIAL)
- POTENTIAL REVOCATION DOES NOT APPLY TO ALREADY RELEASED INFO _____ (INITIAL)
- THIS AUTHORIZATION WILL EXPIRE IF EXPIRATION DATE IS GIVEN _____ (INITIAL)
- IF EXPIRATION DATE IS NOT GIVEN THIS AUTHORIZATION WILL NOT EXPIRE _____ (INITIAL)
- EXPIRATION DATE _____ (NOT REQUIRED)
- THIS AUTHORIZATION IS VOLUNTARY _____ (INITIAL)

PATIENT/GUARDIAN SIGNATURE _____
DATE _____
RELATIONSHIP TO PATIENT (IF GUARDIAN) _____
WITNESS SIGNATURE _____