Jones Family Practice Clinic

Robert Jones, APRN-CNP

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name _____ Date of Birth _____

By state law, you must be advised that: THE INFORMATION YOU AUTHORIZE FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NON-COMMUNICABLE DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND HUMAN IMMUNODEFICIENCY VIRUS (HIV) ALSO KNOWN AS ACQUIRED IMMUNE DIFICIENCY SYNDROME (AIDS)

The information is to be released **FROM**:

☐ Jones Family Practice Clinic
1118 W Broadway St
Muskogee, OK 74401
Ph: 918.912.5372 / Fax: 918.912.5373

☐ Other: Name:_____
Address:_____
City:_____ St:_____ Zip:_____
Phone:_____ Fax:_____

The information to be released is:

☐ **All Records** ☐ History/Physical Exam ☐ Consultation ☐ Operative Report(s) ☐ X-Ray Reports

☐ Lab/Pathology ☐ Pap Smear/Biopsy Results ☐ Prenatal Records ☐ Other_____

The information is to be released **TO**:

☐ Other

☐ Other: Name:_____
Address:_____
City:_____ St:_____ Zip:_____
Phone:_____ Fax:_____

☐ Jones Family Practice Clinic
1118 W Broadway St
Muskogee, OK 74401
Ph: 918.912.5372 / Fax: 918.912.5373

I hereby authorize the above named provider/facility and his/her authorized agents and employees to release the specified information from the above named patient's specified health record(s).
I understand that this authorization will automatically expire six months from this date but may be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. Information released may include alcohol and drug abuse records protected under the Code of Federal Regulations and psychiatric records, if any. Re-disclosure of this information by the recipient is prohibited without specific authorization. I waive all rights and privileges allowed by law relating to disclosure of confidential information and release the facility, its agents, and employees from legal responsibility arising from the release of this information.

_____ _____ _____
Signature of Patient or Representative of Minor | Date | Relationship to Patient