Oklahoma Kids Pediatrics
Sara Buntin, APRN, CPNP

AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION

Patient's Full Name: ________________________________ Date of Birth: ______________________

I hereby authorize Oklahoma Kids Pediatrics Sara Buntin, APRN, CPNP, PLLC staff to

______ **release or** ________ **obtain** records pertaining to my medical care and treatment which could include information about communicable disease, venereal disease, mental health, or drug, substance, or alcohol abuse.

RELEASE TO:	**OBTAIN FROM:**
______________________________ Name of Designated Facility	______________________________ Name of designated facility/provider
______________________________ Address	______________________________ Address
______________________________ City, State, Zip Code	______________________________ City, State, Zip Code
______________________________ Phone Fax	______________________________ Phone Fax

Information to be released:

_____ All Medical records _____ Vaccine record _____ Last Visit _____ Other: ______________________

Purpose for which request is being made:

_____ Transfer of Care _____ Self _____ Attorney _____ Other ______________________

My Rights:
I understand that I do not have to sign this authorization to obtain health care benefits. I may revoke this authorization in writing by following the process described in the Notice of Privacy Practices posted in this office. I understand that the provider has no control over any information/records released to any other person, firm or agency under this authorization and it is, therefore, possible that a release of this information/records may occur by such other party. I understand that if I am requesting records for release to me or a patient representative, laws may prevent certain records from being released to the patient, parent or legal guardian but in certain situations, patients may request a copy of the denial.

I release Oklahoma Kids Pediatrics Sara Buntin, APRN, CPNP, PLLC and staff from any liability in connections with use or disclosure of the records released to any party pursuant to this Authorization.

____ ______________

Signature of Patient or Patient's Authorized Representative Relationship to Patient Date