MEDICAL RECORDS RELEASE AUTHORIZATION

Welcome to South Tulsa Pediatrics

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Patient's Name(s): _____ Date(s) of Birth: _____
_____ _____
_____ _____
Patient's Phone #: _____

___ **I am requesting my South Tulsa Pediatrics records to be sent to:**

Physician/Clinic Name: _____
Address: _____
City, State, Zip Code: _____
Phone: _____ Fax: _____

___ **I am requesting my previous records to be obtained from:**

Physician/Clinic Name: _____
Address: _____
City, State, Zip Code: _____
Phone: _____ Fax: _____

___ **I am requesting my records into my own keeping.**
(I agree to pay $1.00 for the first page and 50 cents for each additional page before such are released and will also pay the actual cost of postage if the record is to be mailed.)

Description of information to be disclosed: _____
_____
Reason for requested use or disclosure: _____
_____

I further release the entities listed above, their agents and employees from liability in connection with the use and disclosure of the protected health information covered by this authorization. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law.

According to Oklahoma State law you must be advised**: The information authorized for release may include records which indicate the presence of a communicable or non-communicable disease. I further understand that medical information may indicate that the patient has or has been treated for psychological or psychiatric conditions or substance abuse.**

I realize by the release and/or receipt of these records that I am accepting responsibility for the protection of my own right of medical record confidentiality.

_____ _____
Signature of Patient Date

_____ _____
Signature of person authorized to sign if other than patient Relationship to patient