Authorization For the Release of Medical Information

Drs. Fox and Fields
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Patient Name:____ Date of Birth___________________________

I hereby authorize Dr.__________________________ to release photocopies of my child's medical records and/or heath information…

To the following named individual or organization: ____

Address: ____

□ Pickup □ Mail

____

Phone/Fax: (______)____________-_________________

This information will be obtained, used, or disclosed for the following purpose:
□ Continued treatment □ Personal Use □ Transfer
□ Other____

Information to be released:
□ Complete Record □ Immunization Record □ Records during: ___/___/___-___/___/___
□ Records concerning____

I agree to pay $0.50 per page before such are released and will also pay the actual cost of postage if the record is to be mailed.

I further release Dr.________________________ from responsibility for any deleterious effect the release of my child's clinical medical records may have upon myself or others both now and in the future. I personally accept all responsibility for my own distribution and interpretation of medical information contained therein and I hold blameless the Office of Sooner Pediatrics for conclusions or opinions drawn from said records without professional knowledge, assistance, or review.

By State Law, you must be advised that: the information authorized for release may include records which may indicate the presence of communicable or venereal diseases which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus also known as Acquired Immune Deficiency Syndrome (AIDS).

I realize by 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 parent/ patient/ guardian Date

Date Received__________________ Date Released____/_____/______ # pages _______