Clinton
REGIONAL HOSPITAL
Primary Care
Dr. Nadia Azuero

Oklahoma Medical Records Release Authorization

Name:_____ DOB:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone:_(___)_____ Email:_____
Social Security Number (last 4 digits): _____

I AUTHORIZE THE FOLLOWING PRACTITIONER/FACILITY TO RELEASE MY MEDICAL INFORMATION:

Practitioner/Facility:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone:_(___)_____ Fax:_(___)_____

RELEASE MY MEDICAL INFORMATION TO:

Clinton Regional Hospital
Dr. Nadia Azuero
100 N. 30th Street Suite 7 Clinton, OK 73601
Phone: (580) 547-5043 Fax: (580) 547-5035

INFORMATION TO BE RELEASED: (Check all that apply)

☐ Complete Medical Record ☐ Medical records from: __/__/__ to __/__/__
☐ Lab results from:__/__/__ to __/__/__ ☐ Immunization records
☐ Radiology reports from:__/__/__ to __/__/__ ☐ Billing records
☐ Other (please specify): _____

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PURPOSE OF RELEASE: (Check all that apply)

☐ Establish care ☐ Continuing care ☐ Transfer care ☐ Personal use ☐ Insurance ☐ Legal
☐ Disability Determination ☐ Worker's compensation
☐ Other (specify): _____

SPECIAL AUTHORIZATION FOR SENSITIVE INFORMATION:

Oklahoma law requires specific authorization for the release of certain types of medical information. By initialing below, I specifically authorize the release of the following information:

☐ Mental Health Records (excluding psychotherapy notes)
☐ Alcohol/Drug Abuse Treatment Records ☐ Sexually Transmitted Disease Information
☐ HIV/AIDS Test Results and Treatment Records ☐ Genetic Testing Information

EXPIRATION AND REVOCATION

The authorization will expire on: ☐ ___/___/___ (specific date) ☐ One year from signing date
☐ When the following event occurs: _____

I understand that I have a right to revoke this authorization at any time by sending a written notification to Clinton Regional Hospital. I understand that a revocation is not effective to the extent that the practitioner has relied on this authorization to use or disclose my health information.

NOTICE OF RIGHTS AND OTHER INFORMATION

I understand that:

- I may refuse to sign this authorization and that my refusal will not affect my ability to receive treatment, payment, enrollment, or eligibility for benefits.
- I may inspect or copy the information to be used or disclosed as provided in 45 CFR 164.524 (HIPAA regulations).
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.
- If I have questions about the disclosure of my health information, I may contact the Clinton Regional Hospital Privacy Officer.

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In accordance with Oklahoma State Law, I understand that I may be charged a reasonable fee for the copying of medical records. Oklahoma Law allows a fee of $1.00 for the first page and $0.50 for each additional page, plus postage.

Signature of Patient or Legal Representative:_____

Date: __/__/__

Relationship to Patient:_____

Witness Signature: _____

Date: __/__/__

FOR OFFICE USE ONLY

Date Request Received: __/__/__

Request Processed By: _____

Date Information Released: __/__/__

Delivery Method: ☐ Mail ☐ Fax ☐ Email ☐ In Person ☐ Other:_____