Putnam North Family Medical Center
Authorization for the Release of Health Information

I hereby authorize the Putnam North Family Medical Center to disclose my individually identifiable health information as described below.

Patients Name (Please Print) Social Security Number Date of Birth

Name and address of the person(s) or organization(s) requesting the records.

_____

_____

_____

_____

Name and address of person(s) or organization(s) to receive the records:

_____

_____

_____

_____

☐ I wish to have the following records copied, and I will pick them up at the facility.

☐ I wish to review my records at the facility.

☐ I am requesting that the facility copy the following records, and send the records to the above address.

Information Requested

I am requesting the following protected health information created between ____/____/____ and ____/____/____.

Information requested:

_____ Complete Record (every page)

_____Progress Notes _____ Medication List _____Laboratory Reports

_____Pathology Reports _____X-Ray Reports _____History & Physical

_____OB Record _____Immunization Record _____Operative Reports

_____ Mammogram Report _____Other _____

Purpose for which the records will be used:_____

_____

I understand this authorization is subject to revocation by me at any time except to the extent that action has been taken in reliance on it. I understand that the information authorized for release may indicate the presence of a non communicable or communicable disease which may include, but not limited to, diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS).

I understand that this authorization is voluntary.

I agree to release the Putnam North Family Medical Center, its affiliates, agents and employees from any liability in connection with the release of the requested information.

I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by the Putnam North Family Medical Center if the recipient of the information is not a health plan, health care provider, health care clearinghouse, or a business associate that has a contract with the Putnam North Family Medical Center.

I understand that I must provide the Putnam North Family Medical Center with at least twenty-four hours notice before coming to the facility to review the records maintained on site, and a reasonable amount of time for records maintained off site, as defined by Oklahoma statute.

I understand that the Putnam North Family Medical Center may assess a fee for copying the records that I requested, which has been set by Oklahoma law as follows: (a) one dollar for the first page, (b) fifty cents per page for each additional page, (c) the actual cost of any postage incurred in compliance with 76 Okla. Stat § 19.

I understand that the Putnam North Family Medical Center will notify me of the total amount due for copying and shipping of the requested records and I agree that the Putnam North Family Medical Center will only send me the requested information once it has received payment in full for the cost incurred in honoring my request.

_____

Patient Signature **Date**

Complete the following if the patient is deceased, a minor, or mentally incapacitated.

_____ _____

Signature **Relationship to Patient**

_____ _____

Date **Reason Unable to Sign**

NOTE : THIS CONSENT WILL BE HONORED FOR A PERIOD OF 180 DAYS FOLLOWING ITS EXECUTION.

The requested protected health information was released in accordance with this authorization on _____.

_____

Putnam North Family Medical Center Representative