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

I the undersigned hereby authorize _____ to release copies of certain medical record information as specified below.
(name of facility)

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:

Putnam North Family Medical Center

11220 N. Rockwell Ave

Oklahoma City, OK 73162

_____

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

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

Information Requested (please initial)

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

Information requested:

_____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 communicable or venereal 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).

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.