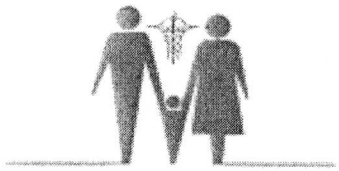

PLEASE SEND RECORDS TO:

Classen Family Medicine
432 N Broadway Ave, Shawnee, OK 74801
Phone: 405-395-4441 Fax: 405-395-2163

Records Request Consent

PATIENT INFORMATION:
PATIENT'S NAME:_____ DATE OF BIRTH:_____
PREVIOUS NAME:_____ SOCIAL SECURITY:_____

I AUTHORIZE THE FOLLOWING ENTITY:
FACILITY/PROVIDER NAME:_____
ADDRESS: _____
CITY, STATE, ZIP:_____
PHONE:_____ FAX:_____

TO SEND MY MEDICAL INFORMATION FROM (date) _____ to (date)_____
TO CLASSEN FAMILY MEDICINE CLINIC FOR THE PURPOSES OF:
☐ Continuation of Treatment
☐ Patient Request
☐ Prior Authorization/Pre Certification
☐ Other:_____

THE RECORDS MAY INCLUDE:
☐ Behavior Programs
☐ Summary Reports
☐ Emergency Room Records
☐ Immunization Records
☐ Psychotherapy Notes (Excludes all other types of records)
☐ Medical Records
☐ Entire Record(Excludes Psychotherapy notes)
☐ Other:_____

I understand that:

- Protected Health Information (PHI) is health information that identifies me. The purpose of this authorization is to allow the Provider to share my PHI as set forth above.
- I have been informed what information will be given, it's purpose, and who will receive the information.
- I understand that this is voluntary and that I have the right to refuse to sign this authorization. If I refuse to sign this authorization, I will still be eligible to receive medical services from the Provider.
- I understand that my PHI may include sensitive information such as treatment regarding HIV/AIDS, sexually transmitted disease, and drug and /or alcohol abuse.
- This authorization may result in the Provider disclosing my medical information to a recipient who could possibly later use or disclose the information without my authorization. The Provider cannot control re-disclosure by Recipient.
- If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
- I have been informed this consent automatically expires after one year from signed date.
- I understand I may revoke this consent at any time by providing written notice. If I revoke, my information will not be disclosed by the Provider, except as otherwise permitted by law. This will not affect any actions taken in reliance of my previous authorization.
- I may inspect or copy the information that will be disclosed or used for the purposes set forth in this authorization. I will receive a signed copy of this authorization and may contact the Provider to get a copy if I do not have one.

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Printed Name of Patient or Patient's Representative Relationship

Attach documentation of description of Representative's authority (Power of Attorney, Legal guardian, etc.)