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

RELEASE OF INFORMATION CONSENT

PATIENT INFORMATION:

PATIENT'S NAME: _____ DATE OF BIRTH: _____

PREVIOUS NAME: _____ SOCIAL SECURITY #: _____

I AUTHORIZE Classen Family Medicine TO SEND MY MEDICAL INFORMATION FROM (DATE) _____ TO (DATE) _____ TO THE FOLLOWING AGENCIES OR PERSONS:

FACILITY /NAME: _____

ADDRESS: _____

PHONE: _____ FAX: _____

EMAIL ADDRESS: _____

FACILITY /NAME: _____

ADDRESS: _____

PHONE: _____ FAX: _____

EMAIL ADDRESS: _____

FACILITY /NAME: _____

ADDRESS: _____

PHONE: _____ FAX: _____

EMAIL ADDRESS: _____

FOR THE PURPOSES OF:

- ☐ CONTINUATION OF TREATMENT
- ☐ PATIENT REQUEST
- ☐ PRIOR AUTHORIZATION /PRE CERTIFICATION
- ☐ OTHER: _____

THE RECORDS MAY INCLUDE:

- ☐ RADIOLOGY REPORTS
- ☐ LAB RESULTS
- ☐ BILLING INFORMATION
- ☐ IMMUNIZATION RECORDS
- ☐ PSYCHOTHERAPY NOTES (EXCLUDES ALL OTHER TYPES OF RECORDS)
- ☐ MEDICAL RECORDS
- ☐ ENTIRE RECORD (EXCLUDES PSYCHOTHERAPY)
- ☐ 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 care provider, the release 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 my contact the Provider to get copy if I do not have one.

_____ _____ _____

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE DATE RELATIONSHIP