COHESIVE
FAMILY MEDICINE

Authorization for Release of Medical Record Information:

Patient Name:_____ Today's Date:_____

Date of Birth:_____ Patient Phone Number:_____

Address:_____ City/State/Zip:_____

Please Note: Copy Fee May Be Charged for Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name:_____ Facility Phone Number:_____

Facility Address:_____ City/State/Zip:_____

Facility Fax Number:_____

Dates and Type of Information to disclose:
□ 2 years prior from last date seen
□ Dates Other: _____
□ Specific Information Requested:
_____

The purpose of disclosure is:
□ Change of Insurance or Physician
□ Continuation of Care
□ Referral
□ Other _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the dates on this authorization unless other dates specified.

I understand the information in my health record may include information relating to sexually transmitted diseases acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: Cohesive Family Medicine
Address: 2508 N. Harrison City/State/Zip: Shawnee, OK 74804 □ Please mail records
Fax: 405-857-3122 Phone: 405-585-2030 ☒ Please fax records

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will apply to information that has already been released in response to this authorization. I understand that the revocation will apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____.
If I fail to specify an expiration date, event or condition, this authorization will expire 1 year form the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information being used or disclosed as provided in CFR 164.524. I understand that 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 can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Signature of Patient/Guardian:_____ Date:_____