South Pointe
PEDIATRICS

1615 S Eucalyptus Ave
Suite 210
Broken Arrow, OK 74012

phone: 918-254-6822
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# Authorization for release of medical information

Patient Information

PRINT Patient Name in Full Date of Birth

I hereby authorize SOUTH POINTE PEDIATRICS and its agents and employees to ___release or ___obtain (please check the appropriate space) information and copies of records pertaining to my medical care and treatment which could include information about communicable or venereal disease, mental health, or drug, substance or alcohol abuse.

| Release to: | Obtain from: |
|---|---|
| Name of designated Facility or Provider | Name of designated Facility or Provider |
| Address | Address |
| City, State, Zip Code | City, State, Zip Code |
| Phone Number Fax Number | Phone Number Fax Number |

Information to be released:
___ All Medical Records
___ The most recent 2 years of pertinent information (chart notes, labs, x-rays, and special tests)
___ Specific Information (please specify): _____

Purpose for which request is being made (please check on of the following):
___ Physician _____Medical Claims Processing _____Self _____Attorney _____Other_____

I understand that if I am requesting records/information for release to me or a patient representative:
- laws may prevent certain records from being released to the patient
- in certain situations, records denied for release to the patient may allow patient to request and obtain a review of the denial

Drug/Alcohol Abuse Treatment Records: This category of medical information/records is protected by federal confidentiality rules(42 CFR Part 2). The federal rules prohibit anyone receiving this information on records from making further release unless further release if expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I, the undersigned, hereby authorize the release of my (or give relationship) medical record as specified above. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug related conditions, alcoholism and/or psychiatric/psychological conditions to the above mentioned entity(s).

The information authorized for release may include records which may indicate the presence of a communicable disease or non-communicable disease.

My Rights:
I understand that I do not have to sign this authorization in order to obtain health care benefits. I may revoke this authorization in writing by following the process described in the Notice of Privacy Practices posted in the office. I understand that the provider has no control over any information and records released to any other person, firm or agency under this Authorization and it is, therefore, possible that a release of this information or records may occur by such other party.
Reasonable Fee:
State law provides that a health care provider may charge a reasonable fee.

I release the provider, its employees and agents from and liability in connections with the use or disclosure of the information and records released to any party pursuant to this Authorization.

| | |
|---|---|
| Signature of Patient or Patient's Authorized Representative | Date |
| Reason Patient Unable to Sign | Relationship to Patient |

## Additional Contact Questions

Who should receive billing statements? _____
May ALL contacts have access to the patient's records electronically? Yes / No / _____

*If parents are divorced or separated, please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment?
Yes / No
If yes, please explain and provide a copy of any legal paperwork that supports this restriction.
_____
_____

*Emergency Contacts, other than parents: Name & Relationship to Patient
1: _____-_____ Phone: (_____) _____ - _____
Name Relationship

2: _____-_____ Phone: (_____) _____ - _____
Name Relationship

SOUTH POINTE PEDIATRICS, P.C.

PLEASE READ AND SIGN:

I understand and agree that, regardless of my insurance status I am ultimately responsible for the balance on my
professional services rendered. I will notify you of any changes in my insurance status or any other demographic
request that insurance payment of authorized medical benefits, if any, be made to South Pointe Pediatrics on my
unpaid services rendered by South Pointe Pediatrics.

I consent to the use and sharing of my health records for treatment, payment, and operational purposes as descr
TICE OF PRIVACY PRACTICES. Oklahoma law requires that we advise you that the information authorized for discl
information which may be considered a communicable or venereal disease, including, but not limited to, Hepatit
orrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS). It also may include r
other sensitive information. By signing this agreement, you are consenting to such disclosure.

A complete description of how your medical information will be used and disclosed by this practice is in our NOT
PRACTICES, which you should read before signing this agreement.

Signature of Patient, Parent or Legal Guardian Relationship Date