First Priority Medical Clinic
2514 E 15th St, Tulsa, Oklahoma 74104
918-398-6993 fax 866-573-0793

AUTHORIZATION TO RELEASE MEDICAL RECORDS

THERE IS A $25 CHARGE TO RECEIVE A COPY OF YOUR RECORDS COPIES FOR OTHER DOCTORS ARE FREE OF CHARGE

I ___________________________________, hereby authorize

FIRST PRIORITY MEDICAL CLINIC, 2514 E 15th St, Tulsa, Oklahoma 74104

To disclose the following specific medical information by ___mail or ____fax TO:

INFO OF OFFICE THAT WILL BE RECEIVING YOUR RECORDS

Name:____
Address: ____
City, St., Zip: ____
Office Telephone:________________________ Fax:__________________________

From the Health Records of:

PATIENT'S INFORMATION

Name: ______________________________DOB_____________Last 4 of SS#____________
Address: ____
City, St., Zip: ____

For the purpose of: ____

My authorization extends only to those data elements/documents initialed below:

_____ Statements of charges or payments
_____ Progress Notes
_____ Discharge summary
_____ Consultation Reports
_____ Record of visit for specific date or dates specific dates include or are limited to: ________________
_____ Copies of records or reports provided to the above named (i.e.hospital, lab, clinic, etc)
_____ All of the above
_____ Other (Must be specific) ____ Mental Health and/or alcohol and drug abuse treatment _____ Hepatitis information
_____ Records of visits (all visits)
_____ Photographs, videotapes, digital or other images
_____History and Physical Examination

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available from the receptionist.
4. North Country Family Practice, P.A., its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this Authorization.
6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

____ ________________________
Patient's Name Printed Date

____ ________________________
Patient's signature (or guardian, if a minor) Expiration date (if other than one year from date above)

____ ________________________
Social Security Number (for identification purposes only) Date of Birth

____ ________________________
Patient's Personal Representative Date

____
Patient's Personal Representative's Authorization to Act

____
Witness