# Authorization for Medical Records

I, _____ , authorize CareATC to Release or Request my medical records as directed below.

## Patient Information

Patient Name _____ Date of Birth _____

Address _____ Last 4 of SSN _____

City _____ State _____ Zip _____

Mobile Phone _____ Work Phone _____

Email Address _____ Employer _____

## Information to be disclosed from my medical record: (check appropriate boxes) Date Range: _____ to _____

- ☐ Consultation
- ☐ Immunizations
- ☐ Medication/Allergy List
- ☐ Complete Medical Record (Designated Record Set)
- ☐ History/Physical Exam
- ☐ Lab/Pathology/ Radiology Reports
- ☐ Progress Notes
- ☐ Other: _____

## Sensitive information will not be released unless specifically authorized below: (check appropriate boxes)

- ☐ Drug and Alcohol Test Results
- ☐ Mental Health Treatment Records
- ☐ STI Test Results

Delivery instructions- **Please select one**: ☐ Email ☐ Mail ☐ Fax

## Purpose of Request: ☐ Release Medical Records ☐ Request Medical Records

Name _____

Address _____

City _____ State _____ Zip _____

Fax _____ Email Address _____

**Purpose of request:** ☐ Patient Request ☐ Referral ☐ Other: _____

**I understand:**

- I may revoke this Authorization at any time by providing my written revocation to the address at the bottom of this form. My revocation will not apply to information already retained, used, or disclosed in response to this Authorization. Unless sooner revoked, the expiration date of this Authorization will be one (1) year from the date of the signature.
- Information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.
- The information authorized for release may include records of sensitive nature that may indicate the presence of Sexually Transmitted Infections (STI's).
- The information authorized for release may include protected health information related to mental health. Release of mental health records or psychotherapy notes may require consent of the treating provider or a court date.
- The information authorized for release may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules (42CRF Part 2). The Federal rules prohibit anyone receiving this information or record from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or is 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. As a result, by signing below, I specifically authorize any such records included in my health information to be released.
- I waive all rights and privileges allowed by law relating to disclosure of confidential information and release the facility its agents and employees from legal responsibility arising from the release of this information.
- This release shall expire in one (1) year from the date of signature or on (please specify expiration date or event) _____

**Patient Signature (or Representative if Minor):** _____ **Date:** _____

**Relationship to Patient:** _____

4500 S 129th E Ave Ste 191 Tulsa, OK 74134 T: 918-779-7479 F: 855-474-4546 Email: medicalrecords@careatc.com