NORTHERN OKLAHOMA REGIONAL PEDIATRIC CLINIC, PLLC
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Request for an individual's Heath Information/Authorization to Release

Last Name: _____ First Name: _____

Other Names Used: _____

Date of Birth: _____ SS#: _____

Address: _____

Home Phone: _____

I hereby request access to the protected health information in my heath record covering the period from

(Date) _____ to (Date) _____

Purpose of Request: _____

□ ***ENTIRE HEALTH RECORDS***	□Ref/Prior Auth/OP Orders	□Special Studies/Forms
□Health Maintenance	□Hospital Records	□Triage Notes
□Vital Signs	□Outgoing Correspondence	□Outside Med Recs
□Clinical Elements	□Message Documentation	□RX
□Historical Medications	□Consent/Auth/Med Recs	□Demographic Forms
□Progress Notes	□X-ray/Reports/Films	□Ins/Billing/Legal Docs
□Laboratory Data	□MRI/CT/Ultrasound	□Allergy Treatment
□Microbiology	□Incoming Correspondence	□Sensitive Info
□Lab Miscellaneous		

☐ I will pick up copies of my records ☐Mail Copies to the individual noted below ☐Fax Copies to Fax #:_____

Records From: _____ Phone#: _____

Records To: _____ Phone#: _____

I understand: 1) I may revoke this Authorization at anytime by providing my written revocation to the address at the top of this form. My revocation will not apply to information already retained, used or disclosed in response to this Authorization. Unless revoked the automatic expiration date will be twelve (12) months from the date of signature. **2)** Unless the purpose of this Authorization is to determine payment of a claim or benefits, NORC may not condition the provision of treatment or payment for my care on my signing this Authorization. **3) THE INFORMATION AUTHORIZATED FOR RELEASE MAY INCLUDE RECORDS THAT MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR NONCOMMUNICABLE DISEASE. 4)** The information Authorized for release also may include protected health information related to mental health. **5)** ***I understand that if my records are released, I will be charged $0.50 for each page for paper records, for records on CD or Faxed I will be charge $0.30 plus amount of postage if records are mailed and payable prior to the release of the requested records.*** **(Make checks payable to Northern Oklahoma Regional Clinic)**. ***Those fees have been set by the Oklahoma State legislature.***

_____ _____

Signature of Patient, Parent, or Legal Authorized Representative **Relationship to patient** **Date**