OFFICIAL USE ONLY
Acct#_____
Place on File Only: [ ]

ADVANCED ORTHOPEDICS OF OKLAHOMA
2488 E 81st St. Ste 700
Tulsa, OK 74137
Ph: 918-927-3304 Fax: 918-927-3201

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Please fax this release back to 918-927-3201

Patient's Last Name	Patient's First Name	Initial	Date of Birth

Recipient's Name	Phone #	Fax #

Address	City	State	ZIP Code

Description of Information to be Used or Disclosed

All Date(s) Requested:_____ Body Part(s):_____

- ☐ Complete Medical Record
- ☐ MRI Report
- ☐ Physical Therapy Records
- ☐ Office Notes
- ☐ CD of Images
- ☐ Operative Report
- ☐ Billing Records
- ☐ Other:

Purpose of Request

- ☐ At patient/representative request
- ☐ Further Treatment
- ☐ Insurance Company
- ☐ Attorney/Legal
- ☐ Other:

I hereby authorize Advanced Orthopedics of Oklahoma and its agents and employees to release or obtain information and copies of records pertaining to my medical care and treatment.

I acknowledge that the information authorized for release may indicate the presence of a communicable or noncommunicable disease.

This Authorization:

1. Will expire in 12 months or_____.
2. I understand that I have the **right to refuse to sign this authorization** and that my signature is not required for obtaining treatment, payment, enrollment in the health plan, or eligibility for benefits unless the sole purpose of this authorization is to determine payment of a claim or benefit.
3. I understand that I have a **right to receive a copy** of this Authorization.
4. I understand that I have the **right to revoke this authorization in writing** at any time. To obtain information on how to revoke this authorization, contact the Advanced Orthopedics of Oklahoma Medical Records Department. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to my authorization.
5. I understand that I have **the right to inspect or copy the health information** I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Medical Records Department.
6. I understand there may be charges associated with processing this request.

WARNING: We have no control over any information and records released to any person, firm or agency under this Authorization and it is therefore possible that a release of this information of records may occur by such a party.

Release: I release Advanced Orthopedics of Oklahoma and its employees and agents from any liability in connection with the use or disclosure of the information and records released to any party pursuant to this Authorization.

Patient's Signature	Date

Personal Representative Print Sign	Relationship	Date