_____ _____

Patient Name **Date of Birth**

PRIVACY NOTICE

I have been provided a copy of Muskogee Family Medicine HIPAA notice of privacy practices

RELEASE OF MEDICAL RECORDS

I authorize the physicians of Muskogee Family Medicine to provide medical care to the patient. Also, to release any medical information necessary to process claims and request payment of benefits from Medicare or other insurance to myself or to this clinic.

In addition to the above statements, I also authorize release of my protected health information to the following persons:

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

Note: If no individuals are listed above, the patient and/or legal guardians are the ONLY persons who will have access to ANY health information. If you would like your spouse to have access to your health information, you MUST list them here

_____ _____

Patient or Parent/Guardian Signature Date

_____

Printed name of Signer (if different than patient)