Brad McIntosh, M.D.

Jason Dansby, M.D.

Justin Roberts, APRN-CNP

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

____ ________________ __________________

Patient Name Date of Birth Social Security Number

By state law, you must be advised that: THE INFORMATION YOU AUTHORIZE FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NON-COMMUNICABLE DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO , DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND HUMAN IMMUNODEFICIENCY VIRUS (HIV) ALSO KNOWN AS ACQUIRED IMMUNE DIFICIENCY SYNDROME (AIDS)

The information is to be released **FROM**:

( ) Muskogee Family Medicine

3330 W Okmulgee

Muskogee, Ok 74401

Ph: (918)682-4318 Fax: (918)682-0615

( ) Other: Name:____

Address:____

City:______________________________St:_____Zip:__________

Phone:_______________________Fax:______________________

The information to be released is:

( ) **All Records** ( ) History/Physical Exam ( ) Consultation ( ) Operative Report(s) ( ) X-Ray Reports

( ) Lab/Pathology ( ) Pap Smear/Biopsy Results ( ) Prenatal Records ( ) Other______________________________

The information is to be released **TO**:

( ) Other

Name:____

Address:____

City:___________________________St:_____Zip:_________

Phone:____________________Fax:___________________

( ) Muskogee Family Medicine

3330 W Okmulgee

Muskogee, Ok 74401

Ph: (918)682-4318 Fax: (918)682-0615

I hereby authorize the above named provider/facility and his/her authorized agents and employees to release the specified information from the above named patient's specified health record(s).

I understand that this authorization will automatically expire six months from this date but may be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.Information released may include alcohol and drug abuse records protected under the Code of Federal Regulations and psychiatric records, if any. Re-disclosure of this information by the recipient is prohibited without specific authorization. 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.

____ ________________ __________________

Signature of Patient or Representative of Minor Date Relationship to Patient