(RELEASING from FHCSO)

Family Health Center of Southern Oklahoma

610 East 24th Street	107 E. Post Ave	PO Box 746	1556 S Virginia Ave
Tishomingo, Ok. 73460	Coalgate, OK 74538	Kingston, OK 73439	Atoka OK 74525
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Authorization For FHCSO Release of Medical Information from the circled facility above.

Patient Name:_____ Date of Birth:_____
Social Security:_____ Telephone:_____

I am _____Patient _____Guardian _____Parent of Minor Child _____Personal Representative

And hereby authorize each clinic personnel to disclose medical information on the above named Patient to release medical records to:

Name of Company to receive records: (Facility) _____

Name of Physician:_____ Address: _____

_____

Phone: _____ Fax: _____

Records to release are: ( ) History and Physical ( ) Progress Notes ( ) Lab ( ) X-ray

( ) EKG ( ) Path Reports ( ) Discharge Summary ( ) Op. Reports ( ) All Records

Date(s) of Service From ___/___/___ to ___/___/____ or ( ) includes all dates of services

I understand that this authorization will automatically expire 12 (twelve) months from the date of my signature. I also understand that this authorization can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this authorization. To cancel this authorization, send a written request to the address given above. This authorization is good for 12 months after the date of signature, as well as past information.

Information in your medical record that you have or may have a communicable or venereal disease is made confidential by law and cannot be released without your permission except in limited circumstances, including release to persons who have had risk exposures, release pursuant to an order of the court or the Department of Health, release among health care providers involved in your care or release for statistical or epidemiological purposes. When such information is released, it cannot contain information from which you could be identified unless the identifying information is released to you, by an order of the court or the Department of Health or by law.

I UNDERSTAND THAT MY MEDICAL INFORMATION MAY INDICATE THAT I HAVE NONCOMMUNICABLE, COMMUNICABLE OR VENEREAL DISEAS WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). I FURTHER UNDERSTAND THAT MY MEDICAL INFORMATION MAY INDICATE THAT I HAVE OR HAVE BEEN TREATED FOR PSYCHOLOGICAL OR PSYCHIATRIC CONDITIONS OR SUBSTANCE ABUSE.

Information Release may include alcohol and drug abuse records protected under the Code of Federal Regulations and psychiatric records. Redisclosure of alcohol and drug abuse records by the recipient is prohibited without specific authorization.

_____ _____

Date Signature of Patient Personal Representative

Personal Representative, describe your authority to sign for the patient.

_____

Your health information that you have authorized to disclose may be subject to redisclosure by the recipient and no longer subject to protection under the federal privacy regulations.