Office (405)936-1000
Fax (405)936-1001

Lakeside Doctors

AUTHORIZATION FOR ACCESS BY PATIENT OR RELEASE OF PROTECTED HEALTH INFORMATION (MEDICAL RECORDS)

I hereby authorize the use of disclosure of my health information as described below to the following:

Name of Individual/Facility/Company to Receive PHI

_____

Address/Phone Number:

_____

_____

Name of Individual/Facility to Disclose PHI

_____

Address/Phone Number:

_____

_____

The specific information authorized for use of disclosure:

- All Medical information concerning this patient.
- Medical information of the patient complied between _____to _____
- Only: _____

Dates of Treatment, if known: _____

This information will be obtained, used or disclosed for the following purpose(s) only:
Circle reason: Insurance Continued Treatment Legal At the request of patient's representative
Other (specify): _____

I understand:

- This authorization is voluntary and that I may refuse to sign the authorization.
- The organization authorized to receive my information may not be required by federal privacy regulations to protect my health information. However the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality requirements.
- I may revoke this authorization at any time, in writing, except revocation will not apply to information already used or disclosed in response to this authorization, if already released. I may revoke this document by presenting my written revocation as proved in the Notice of Privacy Practices. Unless revoked or otherwise indicated, the automatic expiration date will be one year from the date of signature or upon occurrence of the following event:_____
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information covered by this authorization. The entity authorized to disclose the information will not be compensated by the recipient for the disclosure, except for the cost of copying and mailing as authorized by law.

I understand that my medical information may indicate that I have a communicable, non-communicable or venereal disease which may include, but not limited to, diseases such as hepatitis, syphilis, gonorrhea or the human immunodeficiency virus (HIV), also known as Acquired Immune Deficiency Syndrome (AIDS).

Patient Name: _____ **Date of Birth:** _____

_____ _____

Signature of Patient or Legal Representative **Date**

_____ _____

Description of Legal Representative's Authority **Expiration Date of Authorization**