PRIMARY CARE ASSOCIATES PC

4150 SE Adams Rd. · Bartlesville, OK 74006
(918) 331-9979 · FAX (918) 331-2399

Authorization for Release of Individually Identifiable Health Information

Patient Name		Contact Phone Number:
Birth Date:	Social Security Number:	Treatment Dates From: To:

Person/Organization information is being **RELEASED TO:**		Person/Organization information is to be **OBTAINED FROM**:	
Name of person/organization/contact person		Name of person/organization/contact person	
Address		Address	
City, State, Zip		City, State, Zip	
Phone	Fax	Phone	Fax:

Specific description of information being released:

____ Billing Information (Financial/Insurance) ____ Chart Notes ____ Lab Reports
____ Immunization Records ____X-Ray Reports and/or Copies ____ Medication List
____Other (must specify) _____

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I UNDERSTAND:

- This may include records involving communicable or venereal disease, psychiatric, drug abuse and/or alcoholism. The information authorized for use or disclosure may include information, which may be considered a communicable, or venereal disease, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).
- This authorization shall be in force and effect until_____ (date or event), at which time this authorization expires.
- I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- Information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed name of Patient or Personal Representative Relationship to Patient