AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Name: **Date:**
Address:

Phone: **DOB:**

I hereby authorize **Oklahoma Pain Center** to release photocopies of my medical records into my own keeping.

The facility, its employees and officers and the attending physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized by the release. I understand this consent can be revoked at any time except for disclosure already made in good faith, in reliance of these records that I am accepting responsibility for the protection of my own right of medical record confidentially.

I acknowledge that the new law of the state of Oklahoma provides the following:

THE INFORMATION AUTHORIZED FOR THE RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

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Signature of Patient Date of signature

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Signature of Person Authorized

S. Blake Kelly, MD ● James Lynch, MD ● Jack Marshall, MD
Karie Stewart, APRN ● Stacy Torres, APRN ● Katherine Gaddis, APRN ● Jennifer McReynolds, PA-C ● Brandon Funk, PA-C
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