OKLAHOMA
PAIN CENTER

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Name: **Date:**
Address:

Phone: **DOB:**

I hereby authorize _____ to release photocopies of my medical records into my own keeping or to the following individual or organizations:

Oklahoma Pain Center
13921 N Meridian Ave
Oklahoma City, OK 73134
Phone: 405-752-9600 Fax: 405-752-9650

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).

_____

Signature of Patient Date of signature

_____

Signature of Person Authorized