ALEXANDER HEALTH CENTER
800 SOUTH TUCKER DRIVE, TULSA OK 74104
PHONE: (918) 631-2241**FAX: (918) 631-2078

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Full Name			❑ Female ❑ Male	Date of Birth	Today's Date
Street Address	City	State, Zip		TU ID#	Contact Number

I hereby authorize ALEXANDER HEALTH CENTER ("Facility") to ❑ **RELEASE** ❑ **OBTAIN** (please check appropriate box) information and copies of records pertaining to my medical care and treatment.

I request my medical records:

❑Lab Reports ❑Pathology Reports ❑ Radiology/X-Ray Reports ❑ Entire Chart ❑ Other, *specify*_____

Release To:	Purpose of Request
	❑ Self, Employment
	❑ Attorney
	❑ Insurance Company
Obtain From:	❑ Physician
	❑ Medical Claims Processing
	❑ Disability
	❑ Other:

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE, OR RELATE TO MENTAL HEALTH OR DRUG, SUBSTANCE OR ALCOHOL ABUSE.

I understand that if I am requesting records/information for release to me or patient representative:

- laws may prevent certain records being released to the patient,
- in certain situations, records denied for release to the patient may allow patient to request and obtain a review of denial.

DRUG/ALCOHOL ABUSE TREATMENT RECORDS: This category of medical information/records is protected by federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressively permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

THIS AUTHORIZATION:

- will expire in 12 months or _____(specified date)
- may be revoked in writing to ALEXANDER HEALTH CENTER, according to the Facility's Notice of Privacy Practices, but prior disclosures will not be affected
- is not required for obtaining treatment or reimbursement for treatment, unless the sole purpose of the Authorization is to determine payment of a claim of benefits
- is required for employment-related substance/alcohol screening

WARNING: We have no control over any information and records released to any person, firm or agency under this Authorization and it is therefore possible that a release of this information or records may occur by such party.

RELEASE: I release ALEXANDER HEALTH CENTER and the Facility listed above, its employees, agents, trustees, and officers and the attending physician from any liability in connection with the use or disclosure of the information and records released to any party pursuant to the Authorization.

Patient Signature: _____Date:_____