AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Information:

PRINT Patient Name In Full _____ Date of Birth _____ Social Security # _____

I HEREBY AUTHORIZE The Tulsa Health Group and/or Dr. Steven Wiseman, M.D. ("Provider") and its agents and employees to **release** or **obtain** (Please circle which one applies) information and copies or records pertaining to my medical care and treatment. **THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESCENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE, VENEREAL DISEASE, MENTAL HEALTH, OR DRUG, SUBSTANCE, OR ALCOHOL ABUSE.**

Release To:

STEVEN R. WISEMAN, MD _____
1435 S. Utica Ave.
Tulsa, OK 74104

Address

Ph: 918-392-4900 Fax: 918-392-4901

City, State, Zip Code & Phone #

Obtain From:

_____
Name of designated Facility or Provider

_____
Address

_____
City, State, Zip Code & Phone #

INFORMATION TO BE RELEASED:

____ **All medical records**
____ **The most recent two years of pertinent information (chart notes, labs, x-rays, and special tests)**
____ **Specific information (please specify):**_____

Purpose for which request is being made (please check one of the following):

___ Physician ___ Medical Claims Processing ___ Self ___ Attorney ___ Other _____

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

- Laws may prevent certain records from 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 the denial.

Drug/Alcohol Abuse Treatment Records: This category of medical information/records is protected by Federal Confidentiality rules (42CFR Part 2). The Federal rules prohibit anyone receiving this information or records from Making further release unless further release is expressly 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 purpose. The Federal rules restrict any use if this information to criminally investigate or prosecute and alcohol or drug abuse patient.

My Rights:

I understand that I do not have the right to sign this authorization in order to obtain health care benefits. I may revoke this authorization in writing by following the process described in the Notice of Privacy Practices posted in the office. I understand that the Provider has no control over and information and records released to any other person, firm or agency under this Authorization and it is, therefore, possible that a release of this information or records may occur by such other party.

Reasonable Fee:

State law provides that a health care provider may charge a reasonable fee.

I release Provider, its employees and agents from any liability in connections with the use or disclosure of the information and records released to any party pursuant to this Authorization.

_____ _____
Signature of Patient OR Authorized Representative Date

_____ _____
Reason Patient Unable to Sign Relationship to Patient

THIS AUTHORIZATION WILL EXPIRE IN 12 MONTHS OR**_____**.