



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

The undersigned hereby authorizes \_\_\_\_\_ to use or disclose copies of certain medical record information as specified below:

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Maiden/Other Name: \_\_\_\_\_ SS#: \_\_\_\_\_

INFORMATION AUTHORIZED FOR USE OR DISCLOSURE:

Breast Images/Films and Reports

Mammograms: \_\_\_\_\_

Breast Ultrasound: \_\_\_\_\_

Date of Treatment: \_\_\_\_\_

Other: \_\_\_\_\_

Purpose or Need for this Disclosure of Information:

Comparison  Permanent Transfer

INFORMATION IS TO BE RELEASED TO:

Comprehensive Breast Center of Oklahoma
3525 NW 56th, Suite C100
Oklahoma City, OK 73112
405-945-0045

I UNDERSTAND:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already obtained, used, or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Practices. Unless Revoked, the automatic expiration date will be six (6) months from the date of signature or upon occurrence of the following event:\_\_\_\_\_
I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information.
Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the Privacy Rule.
THE INFORMATION AUTHORIZED FOR USE OR DISCLOSURE MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). (SEE O.S. SECTION 1-502.2)

With this knowledge, I give my authorization to the release of all information in my medical records, including any information concerning my identity, and release INTEGRIS Health, Inc., its affiliates, agents and employees, from any liability in connection with the release of the information contained therein.

DATE

PATIENT SIGNATURE / LEGAL REPRESENTATIVE

COMPLETE THE FOLLOWING IF PATIENT IS DECEASED, A MINOR, OR MENTALLY INCAPACITATED. AUTHORIZATION MAY BE GIVEN BY A LEGALLY AUTHORIZED REPRESENTATIVE, IDENTIFIED BELOW:

REASON PATIENT UNABLE TO SIGN

SIGNATURE

DATE

RELATIONSHIP