2004 N HWY 81 DUNCAN, OK. 73533
580-252-1911 (P) 580-252-1020 (F)

MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize you to release confidential health information about me by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: _____ *Date of Birth:* ____/____/_____

The information you may release subject to this signed release form is as follows.

_____ *Complete records* _____ *History & Physical* _____*Progress Notes*

_____ *Care Plan* _____ *Lab reports* _____ *Radiology Reports*

_____ *Pathology Reports* _____ *Treatment Record* _____ *Operative reports*

_____ *Hospital Records* _____ *Medication Records* _____ *other (please specify below)*

Release my protected health information to the following physician/ person/facility/ entity/and or those directly associated in my medical care:

Name: _____

Address: _____

City: State: Zip code: _____

The purpose / reason for this release of information are as follows:

Signature: _____ *Date:* _____

_____ _____

Patient Name *Signature of patient or personal representative*

_____ _____

Patient DOB or Social Security number *Printed name of patient or personal representative*