Section A: This section must be completed for all Authorizations

Patient Name:	**Birth Date:**	**Social Security No.:**

Name of Individual/Facility to Disclose PHI: Comanche County Memorial Hospital	**Person To Receive Records:** ☐ **Check Here if Same As Patient**

Address of Individual/Facility to Disclose PHI:	**Address 1:**		
PO Box 129	**City:**	**State:**	**Zip:**
Lawton, OK 73502			
Office:580-250-5835 **Fax: 580-510-7062**	**Area Code and Telephone number:**		

Purpose of disclosure: The information will be obtained, used, or disclosed for the following purpose(s) only:
☐Insurance ☐ Medical Treatment ☐ Legal ☐ At the request of the patient or patient's representative
☐Other (specify):_____

What dates of treatment do you need?

Treatment Dates:

HOW WOULD YOU LIKE TO RECEIVE YOUR RECORDS?

☐ Pick up Records ☐ Mail Records

Information authorized for use or disclosure, or to be obtained: Check all that apply.

☐ **ROI Basics** (Face Sheet, Dictated Reports, Lab, Rad, Progress Notes, and ED record)	☐ **Discharge Summary**	**Clinic Records**	
☐ **ER Records**	☐ **History & Physical**	☐**MMG Surgery**	☐ **Outpatient Cardiac Rehab Records**
☐ **Consultation Reports**	☐ **Lab Reports**	☐**MMG Ortho**	☐ **Outpatient Wound Care Records**
☐ **Cardiology Reports**	☐ **Operative Reports**	☐**MMG Neuro**	☐ **Therapy Records** (PT, OT, ST records)
(Echo, Cardiac Stress Test, etc)	☐ **Pathology Reports**	☐**MMG Podiatry**	☐ **Itemized bill:**
	☐ **Radiology Reports**	☐**MMG Heart &Vascular**	☐ **UB-04**
	☐ **Radiology Images (CD)**	☐**MMG Internal Medicine**	☐ **Other:**
			☐ **Other:**

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) **OR if this does not apply to the patient, check here.** ☐

I understand that:

1. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
2. I may revoke this authorization at any time in writing, except revocation will not apply to information already 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.
3. Information used or disclosed pursuant to the authorization may no longer be protected by federal privacy regulations and may be re-disclosed.
4. I understand that I may see and obtain a copy the information described on this form for a reasonable copy fee, if I ask for it and I may refuse to sign this authorization (it is strictly voluntary).
5. 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 covered by this authorization. The entity authorized to disclose the information will not be compensated by the recipient for the disclosure, except for the cost of copying and mailing as authorized by law. I receive a copy of this form after I sign it. Per 76 Okla Stat 19 Access to Medical Records **Copies are $0.50 cents for each page _____(initial)**
6. "The Information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease."

This authorization will expire **one** year from the date of the signature or upon the following event: (Fill in the Event)
Event:

Section B: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient Guardian or Patient Representative:	**Date:**
Print Name of Patient/Patient Guardian or Patient Representative:	**Relationship to Patient:**

HIM use only:	**Patient account number:**	
Completed by:	**Date Completed:**	**Page count:**