Oklahoma Injury Care

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PLEASE COMPLETE **ONLY** IF YOU HAVE BEEN SEEN BY **ANOTHER DOCTOR** OR YOU HAVE BEEN EXAMINED AT THE **EMERGENCY ROOM**

Release of Medical Records

I hereby authorize _____
(Emergency Department Name/Physician)

_____
(Street Address) (City) (Zip)

_____ _____
(Phone) (Fax)

To release information from my medical, educational, psychiatric/drug/alcohol records

Specifically:

- ☐ All Records
- ☐ History & Physical
- ☐ Operative Reports
- ☐ Discharge Summary
- ☐ Other (Please Specify) _____
- ☐ Nursing Notes
- ☐ Social Serv. Notes
- ☐ Progress Notes
- ☐ EEG/EKG
- ☐ Orders
- ☐ Radiology
- ☐ Laboratory
- ☐ MRI/ CT Scan

From the time period of _____ to _____.

For the following purpose: _____

This information may be released to **OKLAHOMA INJURY CARE**
200 W. BRITTON RD, OKLAHOMA CITY, OK 73114
PLEASE FAX RECORDS TO: 405-755-8001

I understand that the specific type of information to be disclosed may include a history of drug, alcohol, mental health treatment, or communicable disease (IE: AIDS/ HIV/ Hepatitis). I expressly understand and agree that no legal responsibility of any nature shall attach to the attending physician or employee in acting upon this authorization. I understand that I may revoke this content at any time except to the extent that action has been taken in reliance on it and that in any event this content shall expire 90 (ninety) days of patient discharge, unless another date is specified:

(Specification of date or event upon which this consent expires): _____

A photocopy or facsimile of this authorization shall be as effective as an original.

_____ _____
(Date) **(Signature of Patient)**

_____ _____
(Print Patient's Full Name) (Signature of Spouse, Parent, or Guardian)

_____ _____
(Date of Birth) (Relationship)

_____ Male _____ Female

_____
(Witness Signature)