NeoHealth
P.O. Box 751
Hulbert, OK 74441
Phone: (918) 772-3390 | Fax: (918) 772-3638

Medical Records Release Authorization Form

Patient Information (Please Print)

Patient Name: _____ Last _____ First _____ Middle

Address: _____ Street Address _____ City _____ State _____ Zip

Telephone _____ Date of Birth _____ Social Security Number _____ Treatment Date(s)

I hereby authorize NeoHealth and its duly authorized agents and employees to

☐ **RELEASE** **OR** ☐ **OBTAIN**

the protected health information indicated below to/from:

Name: _____ Phone Number: _____

Address: _____
Street Address City State Zip

Requested Information:

I authorize the disclosure of the following types of records from _____ to _____.

- ☐ **Patient History**
- ☐ **Information created or received from other Providers**
  - **Specify:** _____
- ☐ **Hospital & Consulting Physician Summaries**
- ☐ **Billing Records**
- ☐ **Entire Designated Record Set**
- ☐ **Shot Records Only**
- ☐ **Lab Reports**
- ☐ **X-Rays**
- ☐ **Radiology Reports**
- ☐ **Pathology Reports**
- ☐ **Other:** _____

The requested information is/was maintained or created by the following sites/providers:

Name of Physician or Provider	Department	Clinic Location
_____	_____	_____
_____	_____	_____

*Note: Unless you are a provider, you will be charge $1.00 for the first page and $0.50 per page thereafter for paper records, $5.00 per film copied for radiology films, and postage.

Purpose of the Requested Use or Disclosure:

☐ At the Request of the Patient ☐ Other (Indicate Specific Reason) _____

Expiration Date:

This Authorization Will Expire on: ☐ _____ OR ☐ When the Following Event Occurs: _____

(Not to Exceed 6 Months From the Date of This Request)

Your Rights: You may refuse to sign this authorization. Your refusal will not affect your ability to obtain treatment or payment.

1. If the persons or entities authorized to receive this information are not healthcare providers or health plans covered by federal health privacy laws, they may re-disclose the information and those laws would no longer protect the disclosed health information.
2. Once you sign this authorization, we can rely on it until you revoke it, or if you have not revoked it, until it expires. You can revoke this authorization by:

Mailing a signed and dated letter to:	Or in Person at:
Crystal Steed	**Crystal Steed**
NeoHealth COO	**NeoHealth COO**
P.O. Box 751	**129 E Main St.**
Hulbert, OK 74441	**Hulbert, OK 74441**

3. The information authorized for release may include records which indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea, and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS).
4. I understand that the records requested may be protected under 42C.F.R. Part 2, governing Alcohol and Drug Abuse patient records, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R Parts 160 and 164, state laws and regulations regarding the confidentiality of medical records, and cannot be release without my consent unless otherwise provided by applicable law. I understand also that state and federal laws and regulations prohibit any further disclosure of such records without my specific written consent, or when otherwise permitted by law.
5. ☐ If checked, we will receive compensation for our use/disclosure of the information that is the subject of this authorization.

Signature (Patient or Legal Representative: _____ Date: _____

Capacity of Legal Representative * (if applicable): _____ *To provide verification of representative status.