

Northern Oklahoma Regional Pediatric Clinic
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Request for an individual's Health Information/Authorization to Release

Patient's information: Last Name: _____ First Name: _____

Other Names Used: _____

Date of Birth: _____ SS#: _____

Address: _____ Home Phone: _____

I hereby request access to the protected health information in my health record covering the period of
 (Date of service) _____ to (Date of service) _____

Purpose of Request: _____

<input type="checkbox"/> ENTIRE HEALTH RECORDS <input type="checkbox"/> VACCINE RECORDS <input type="checkbox"/> Vital Signs <input type="checkbox"/> Clinical Elements <input type="checkbox"/> Historical Medications <input type="checkbox"/> Progress Notes <input type="checkbox"/> Laboratory Data <input type="checkbox"/> Microbiology <input type="checkbox"/> Lab Miscellaneous	<input type="checkbox"/> Ref/Prior Auth/OP Orders <input type="checkbox"/> Hospital Records <input type="checkbox"/> Outgoing Correspondence <input type="checkbox"/> Message Documentation <input type="checkbox"/> Consent/Auth/Med Recs <input type="checkbox"/> X-ray/Reports/Films <input type="checkbox"/> MRI/CT/Ultrasound <input type="checkbox"/> Incoming Correspondence	<input type="checkbox"/> Special Studies/Forms <input type="checkbox"/> Triage Notes <input type="checkbox"/> Outside Med Recs <input type="checkbox"/> RX <input type="checkbox"/> Demographic Forms <input type="checkbox"/> Ins/Billing/Legal Docs <input type="checkbox"/> Allergy Treatment
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I will pick up copies of my records Mail Copies to the individual noted below Fax Copies to Fax #:580-765-2020

Records From: _____ **Phone#:** _____

Records To: _____ **Phone#:** _____

I understand: 1) I may revoke this Authorization at anytime by providing my written revocation to the address at the top of this form. My revocation will not apply to information already retained, used or disclosed in response to this Authorization. Unless revoked the automatic expiration, date will be twelve (12) months from the date of signature. 2) Unless the purpose of this Authorization is to determine payment of a claim or benefits, NORC may not condition the provision of treatment or payment for my care on my signing this Authorization. 3) **THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS THAT MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR NONCOMMUNICABLE DISEASE.** 4) The information Authorized for release also may include protected health information related to mental health. 5) **I understand that if my records are released, I will be charged \$0.50 each page for paper copies and \$10 for electronic records copied to a CD, payable prior to the release of the requested records. (Make checks payable to Northern Oklahoma Regional Clinic). All records over 100 pages, going to another clinic, will not be faxed. Records can also be accessed via our portal, which can be accessed once an invitation has been sent to join.**

 Signature of Patient, Parent, or Legal Authorized Representative Relationship to patient Date