METRO TULSA
Foot & Ankle
SPECIALISTS

HIPPA COMPLIANT AUTHORIZATION TO OBTAIN CONFIDENTIAL HEALTH INFORMATION

Full Name of Patient: _____

Patient's Date of Birth _____ Medical Record Number: _____

Information Requested: ( ) Entire Record ( ) Progress Notes ( ) X-Ray Documentation
*( ) Lab/Pathology Results ( ) Operative Report ( ) Other (Specify)*_____

Identify the Date (s) of Service requested, including month and year: _____

THE ABOVE RECORD IS TO BE RELEASED TO THE FOLLOWING:

Name, Title and/or Office: Metro Tulsa Foot and Ankle Specialists, PLLC

Street Address: 5711 E 71st Street Suite 220

City/State/Zip: Tulsa, OK 74136 Fax Number: 918-477-9362

THIS RECORD IS REQUESTED FOR THE FOLLOWING REASON:
( ) Continued Medical Care ( ) Legal Purposes ( ) Insurance Purposes
( ) Personal Interest ( ) Other (Specify) _____

The authorization must be signed and dated and may be revoked by notifying Metro Tulsa Foot and Ankle Specialists, PLLC in writing at any time except to the extent action has been taken prior to revocation. This consent will expire 60 days after the date below or sooner, by my choice, in which case this consent will expire on this date or event: _____. Requests for record copies will be handled on a first come, first serve basis with a 72 hour minimum.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. I hereby affirm that I have read and fully understand the above statements and consent to the disclosure of the medical records for the purpose and extent stated above. NOTE: A COPY OF A PICTURE ID MUST ACCOMPANY THIS FORM.

Signature: _____ Date: _____
(Patient, Parent, or Authorized Representative)

Relationship to Patient: _____

Social Security Number: _____ Phone Number: _____

**This information has been disclosed to you from records whose confidentially is protected by federal and/or state law. Federal and State Regulations Prohibit you (the recipient) from making further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.*

PLEASE FORWARD MEDICAL RECORDS TO OUR OFFICE FOR CONTINUATION OF CARE