



OKLAHOMA INSTITUTE
of
ALLERGY ASTHMA & IMMUNOLOGY

Release of Medical Records From Oklahoma Institute of Allergy Asthma & Immunology			
Patient Name:		Date of Birth:	
I hereby authorize Oklahoma Institute of Allergy Asthma & Immunology , 1810 E. Memorial Rd. OKC, OK 73131, P: 405-607-4333 F: 405-607-4404 to release the following information to:			
Person/Organizations Name:			
Address:			
Fax #:			
Information to be shared:			
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Lab. Reports	<input type="checkbox"/> Skin Test	<input type="checkbox"/> Office Notes
<input type="checkbox"/> Diagnosis	<input type="checkbox"/> Pulmonary Function	<input type="checkbox"/> Other	<input type="checkbox"/> All Records
Information may be disclosed for the following purpose:			
<input type="checkbox"/> Insurance	<input type="checkbox"/> Continued Treatment	<input type="checkbox"/> Legal	
<input type="checkbox"/> Representatives Request	<input type="checkbox"/> Own Request	<input type="checkbox"/> Other	
I understand that by voluntarily signing this authorization:			
<ul style="list-style-type: none"> • I authorize the use or disclosure of my medical records as described above for the purpose listed • I have the right to withdraw permission for the release of information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed. • I have the right to receive copies of this authorization. • I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims. • My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have been treated for psychological or psychiatric conditions and/or substance abuse. • I understand I may change this authorization at any time by writing to the person/organization disclosing my records. • I understand I cannot restrict information that may have already been shared based on this authorization • Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the Privacy Regulation. • Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature. 			
Patient Signature:		Date:	
Legal Representative Signature (if applicable):		Date:	