Sooner Urgent Care
2100 W Lindsey St. Ste B.
Norman, OK 73069
Phone: (405) 310-7055

SOONER URGENT CARE

RELEASE OF INFORMATION CONSENT

PATIENT INFORMATION:

LAST NAME_____FIRST_____MIDDLE_____
DATE OF BIRTH_____ SS#_____
ADDRESS_____
HOME PHONE_____WORK PHONE_____

I AUTHORIZE SOONER URGENT CARE TO SEND MY MEDICAL INFORMATION FROM (DATE) _____ TO (DATE) _____ TO THE FOLLOWING AGENCY BELOW:

___OFFICE PROGRESS NOTES ___LAB REPORTS
___X-RAY REPORTS ___IMMUNIZATION RECORDS
___ENTIRE HEALTH RECORD ___OTHER:_____

___ I will pick up my records ___ mail/fax copies of my records to the agency below

FROM:
NAME_____
ADDRESS_____
CITY_____ST____ZIP_____
PHONE_____FAX_____

TO:
NAME_____
ADDRESS_____
CITY_____ST____ZIP_____
PHONE_____FAX_____

I UNDERSTAND THAT:

- Protected Health Information (PHI) is health information that identifies me. The purpose of this authorization is to allow the Provider to share my PHI as set forth above.
- I have been informed what information will be given, it's purpose, and who will receive the information.
- I understand that this is voluntary and that I have the right to refuse to sign this authorization. If I refuse to sign this authorization, I will still be eligible to receive medical services from the Provider.
- I understand that my PHI may include sensitive information such as treatment regarding HIV/AIDS, sexually transmitted disease, and drug and /or alcohol abuse.
- This authorization may result in the Provider disclosing my medical information to a recipient who could possibly later use or disclose the information without my authorization. The Provider cannot control re-disclosure by Recipient.
- If the requester or receiver is not a health care provider, the release information may no longer be protected by federal privacy regulations and may be re-disclosed.
- I have been informed this consent automatically expires after one year from signed date. • I understand I may revoke this consent at any time by providing written notice. If 1 revoke, my information will not be disclosed by the Provider, except as otherwise permitted by law. This will not affect any actions taken in reliance of my previous authorization.
- I may inspect or copy the information that will be disclosed or used for the purposes set forth in this authorization. I will receive a signed copy of this authorization and my contact the Provider to get copy if I do not have one.

_____ _____ _____
SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE DATE RELATIONSHIP