OMEG
OKLAHOMA MEDICAL EYE GROUP

Authorization to Release Protected Health Information

I hereby authorize the use or disclosure of my protected health information as described below. I understand this authorization is voluntary. I understand the medical records released may contain protected health information concerning HIV/AIDS diagnosis or treatment.

Patient's Full Name: _____

Patient's Previous Name: _____

DOB: _____ SS#: _____

Address: _____ City, State, Zip: _____

Person/Organization Requesting Information: _____

_____

_____

Person/Organization Providing Information: _____

_____

_____

Requested dates of Protected Health Information: _____ to _____

Description of Requested Health Information: _____

_____

Reason for Disclosure: _____

_____

I understand that I may revoke this authorization at any time by notifying the requesting person/organization, in writing, that I am revoking this authorization. Such actions will not affect actions taken by the requesting person/organization prior to the date they receive your written request to revoke this authorization.

I understand that this authorization will expire twelve (12) months from today.

_____ _____

Signature of Patient or Patient's Authorized Representative Date

_____ _____

Authorized Representative's Relationship to Patient Date

_____ _____

Witness Date