Authorization for Release of Medical Records

Patient Name: _____
Date of Birth: _____
Phone Number: _____
Records To Be Released
☐ Complete Medical Record   ☐ Office Visit Notes
☐ Lab Results   ☐ Imaging Reports
☐ Immunization Records   ☐ Other: _____

Release Records FROM
Facility/Provider: _____
Address: _____
Phone: _____   **Fax:** _____
Release Records TO
Facility/Person: Jones Family Care, APRN, LLC
Address: 12950 E Britton RD, STE 105, Jones, OK 73049
Phone: 405-399-2900   **Fax:** 405-212-4405

Purpose of Release
☐ Continuity of Care   ☐ Personal Use
☐ Legal   ☐ Insurance
☐ Other: _____

Authorization
I authorize the release of the medical information indicated above. I understand that this authorization is voluntary and may include information relating to mental health, substance use, HIV/AIDS, or other sensitive conditions unless otherwise specified.

Limitations (optional):
This authorization will expire on: _____
(If left blank, expires 1 year from the date signed.)

Signature _____
Patient or Legal Representative: _____
Relationship (if not patient): _____
Date: _____
HIPAA Notice
The information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA. You may revoke this authorization at any time in writing, except to the extent that action has already been taken.