Aspen's Children's Clinic of Broken Arrow
3300 S Aspen Ave Ste. B
Broken Arrow, Ok 74012
Office (918) 455-4140 Fax (918) 455-0170

Authorization for Release of Medical Information

Patient name:_____ **Date of Birth:** _____

Address:_____**City**_____, **State**_____**Zip** _____

PLEASE NOTE IF YOU HAVE MEDICAL RECORDS MORE THAN 20 PAGES PLEASE DON'T FAX TO US. PLEASE SEND BY MAIL ON ABOVE ADDRESS.

Requested Information:

☐ **Immunization Records** ☐ **Most recent Progress Notes** ☐ **X-Ray/Radiology Reports**

☐ **Lab/Pathology Reports** ☐ **Entire Medical Record** ☐ **Mental Health Records**

☐**I will pick up my medical records** ☐**Please fax or mail my records to the Physician Listed below.**

I authorize Aspen's Children's Clinic to release information to new provider:

_____
Name of Provider or Facility

_____
Address

_____ _____ _____
City, State, Zip

_____ _____
Phone Fax

I authorize Aspen's Children's Clinic to obtain information from this Doctor

_____
Name of Provider or Facility

_____
Address

_____ _____ _____
City, State, Zip

_____ _____
Phone Fax

Purpose for this request: ☐ **Specialists** ☐ **Transfer of Care** ☐ **Personal** ☐ **other**_____

I hereby request access to the protected health information in my health record. I understand:

- I may revoke this authorization at any time by providing my written revocation to the address at the top of this form. My revocation will not apply to information already retained, used or disclosed in response to this authorization. Unless sooner revoked, the automatic expiration date of this authorization will be twelve (12) months from the date of signature.
- The information authorized for release may include records that may indicate the presence of a communicable disease or non-communicable disease.
- There may be a charge for the requested records, $1.00 for the first page and .50¢ for each additional page plus mailing costs. There will be charge for records sent to another physician and no charge for updated immunization records given at the time of vaccine administration.

_____ _____ _____
Signature of Patient/Parent/Legal Guardian Date Relationship to Patient