CHOCTAW FAMILY
Medicine & Aesthetics

15809 NE 23rd Street
Choctaw, Ok 73020 Phone

Phone (405) 390-9600
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HIPAA FORM

PERMISSION TO GIVE MEDICAL INFORMATION

I, _____ hereby authorize the physician and staff of CFMA permission to release information concerning my health and well being to the following:

^ ***Patient Name*** ^

Name: _____Relationship:**Mother/Guardian**____Phone Number:_____

Name: _____Relationship:**Father/Guardian**_____Phone Number:_____

Name: _____Relationship:_____Phone Number:_____

Name: _____Relationship:_____Phone Number:_____

O Leave message on answering machine - Phone Number: _____

O I DECLINE to authorize the release of information concerning my health and well being.

The following information may be given to the above individuals: (please check all you agree to):

O Any other information (No limitation) includes all communication.
O Appointment Time
O Procedures
O Test/Lab Results
O Medications

The following items may be picked up on my behalf by the above individuals: (please check all you agree to):

O Written Prescriptions
O Radiology Films
O Any other information regarding my health
O Copy of Medical Records
O Laboratory Results

I understand I may revoke this consent at any time by giving written notice to the person or organization making the disclosure. I understand that this organization originates and maintains health records describing my health history, symptoms, diagnoses, examinations, past/current/future treatments and test results as well as financial information pertaining to my account. I acknowledge that I have been provided with Full Disclosure of their Notice of Privacy Practices and I consent to the use and disclosure of my own or persons form whom I am responsible (i.e. minors) Financial and Health Information for any reason that Choctaw Family Medicine may require in order to carry out Health care operations to or for me and/or for persons whom I am responsible.

Patient Signature: _____ Date: _____
(Parent/Guardian Signature if patient is a minor.)

Witness Signature: _____ Date: _____

If this form is not filled out and/or signed by the patient or legal guardian, no information can be given regarding your medical care to any individual including spouse and/or family members. This includes copies of medical records, radiology films or prescriptions on your behalf. If you have any questions regarding this authorization please ask the receptionist for additional information.

Revised 9/21/2016