FAMILY HEALTH CENTER OF ARDMORE

1104 Walnut Drive
Ardmore, OK 73401
580-226-0543 (f) 580-226-2284

Michael Carnahan, MD Tom McCulloh, DO Miguel Camacho, MD Gina Hernandez,PA-C Sharon Hall, APRN-CNP

AUTHORIZATION FOR ACCESS BY PATIENT OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME:

DATE OF BIRTH:

SOCIAL SECURITY #:

I hereby authorize the user disclosure of the Protected Health Information (PHI) described below to be provided to or obtained by the following:

FAMILY PRACTICE ASSOCIATES OR MIGUEL CAMACHO, MD PC

Name of Person or Facility to Receive Records:	Name of Person or Facility to Send Records:
	Family Practice Associates/Miguel Camacho, MD PC
	1104 Walnut Dr Ardmore, OK 73401
	(580) 226-0543 (ofc) (580) 226-2284 (fax)

PORTIONS TO RELEASE

Doctor's Progress Notes   EKG/ECHO   Operation Report   Lab/Xray   Discharge Summary

Path Report   X-Ray Images   Doctor's Orders   Nurse's Notes   Complete Record   Shot Record

Dates of Service: ______________________________

The information shall be obtained used or disclosed for the following purpose(s) only:

Insurance   Continued Treatment   Legal   Patient's Request   Patient's Representative   Other

AUTHORIZATION

I understand: I may revoke this authorization at any time, in writing, except revocation will not apply to information already used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Practices. Unless revoked or otherwise indicated, the automatic expiration date will be one year from the date of signature or upon occurrence of the following event:____________________________ I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information (PHI) covered by this authorization. The entity authorized to disclose the information will not be compensated by the recipient for the disclosure, except for the cost of copying and mailing as authorized by the law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. I have the right to inspect the health information to be released and I may refuse to sign this authorization. Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment or payment for my care on my signing this authorization.

I understand that my records may indicate that I have a communicable or non-communicable disease which may include, but is not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea or HIV. I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

______________________________ ______________
Signature of Patient or Legal Representative **Date**

______________________________ ______________
Description of Legal Representative's Authority **Expiration Date**

NOTICE OF RIGHTS: Informational your medical record that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including to personas who have had risk exposure, disclosure pursuant to an order of the court or the US Dept of Health, disclosure among health care providers or disclosure for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless

disclosure of that identifying information is authorized by you, by an order of the court or the US Dept of Health or by law.