Oklahoma Joint Reconstruction Institute

Paul B. Jacob, DO

Authorization to Release/Disclose Protected Health Information

Fees must be paid prior to the release of medical records

Patient Name: _____ Date of Birth: _____

Patient Phone #: _____ Social Security #: _____

Patient Address: _____

Street Address City State Zip Code

I authorize the Oklahoma Joint Reconstruction Institute, a division of The Physician Group to release or disclose the following information to:

_____ _____ _____

Name of Person or Entity to receive Information | Phone # (required if faxing) | Fax# (25 pages or less)

_____

Street Address City State Zip Code

Information to be Released/Disclosed: Specific Date(s) of service: _____

☐ Complete Medical Records	☐ Laboratory Reports	☐ Billing Information
☐ Pathology Report	☐ Operative Reports	☐ Radiology Images / CD's
☐ Physician Orders	☐ Radiology Reports	☐ Other: _____

**Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

Purpose for Request:

Purpose:	**Record Disposition:**	**Fees & Postage (If applicable):**
☐ Medical Follow-up	☐ Mail My Records	☐ Retrieval Fee $10.00
☐ Attorney	☐ Fax to number above	☐ Pages 1-50: $0.50 per page
☐ Personal Use	☐ I will pick the up	☐ Pages 51+: $0.25 per page
☐ Insurance	☐ Other: _____	☐ Radiology images on CD: $10.00

This authorization will expire on the following date, event, or condition: _____

If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from date signed.

I understand if the person or agency that receives my information is not a health care provider or health plan covered by the HIPAA privacy regulations, the information described above may be redisclosed and is no longer protected by these regulations.

_____ _____

Signature of Patient or authorized representative Date