

……………….RELEASE OF MEDICAL RECORDS……………….

**Note to Requestor of Records:** There may be a charge for copies of the medical record.

**Note to Recipient of Records:**

The patient’s medical record is privileged information which is protected various State and Federal Laws. Such information may not be further disclosed to other persons without a separate written authorization from the patient.

1. I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, ( DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ )

Authorize PET IMAGING OF OKCto release to the party listed in paragraph 2 the following information from my medical records:

(Check and/or circle appropriate items):

PET scan report  PET scan films  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For the following dates of treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. My medical record may be inspected by and/or copies may be released to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name of Person) (Relationship)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name of Person) (Relationship)

For the purpose of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I may revoke this authorization in writing at any time (except to the extent those actions have been taken in reliance upon it). Unless revoked or renewed in writing, this authorization will expire on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(Date)

If the expiration date is not specified above, this authorization will automatically expire ninety (90) days from the date signed below.

1. If I wish to inspect or have a copy of my PET scan record (for which there may be a charge), I may contact the PET Imaging Center.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

PATIENT SIGNATURE DATE

If the patient is a minor, subject to a guardianship or is deceased, I have signed my name below on behalf of the patient and myself:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

(Patient’s Legal Guardian’s or Agent’s Signature DATE

I witnessed the signature on this form:

Name of Witness (Please Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE OF WITNESS DATE

Mail

Pick up (If the person picking up the records is someone other than the patient, please write the name of the person here.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You will be asked to present a photo ID when picking up medical records.