Norman Endoscopy Center

1515 N. Porter Ave Ste. 100 Norman, OK 73071 P: 405-366-0969 F: 405-701-3734

Authorization for Release of Medical Records

NEC is a HIPAA Compliant Facility

Patient Information:

Name: _____ Birthdate: _____

Street Address: _____ Telephone Number: _____

City: _____ State: ____ Zip Code: _____

I authorize Norman Endoscopy Center to release records to: (Person/Facility to Receive Records)

Name: _____ Telephone: _____

Street Address: _____ Fax: _____

City: _____ State: ____ Zip Code: _____

By placing my INITIALS in the applicable space next to the below listed information, **I understand and authorize the following records will be released**:

_____ History and Physical _____ HIV/AIDS related information

_____ Procedure Reports _____ Drug/Alcohol Treatment information

_____ Pathology Reports _____ Mental Health Information

_____ Other: Please Explain _____

I understand that I may revoke this authorization in writing at any time. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. Unless revoked earlier. This authorization will expire 180 days from the date of signing or on (insert date) _____. I understand the information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected under law. However, I understand that federal or state law may restrict re-disclosure of HIV/AIDS test or result information, mental health information, and drug/alcohol diagnosis, treatment, or referral information.

_____ _____ _____

Signature Relation to Patient Date