OKLAHOMA INSTITUTE of ALLERGY ASTHMA & IMMUNOLOGY

Release of Medical Records to Oklahoma Institute of Allergy Asthma & Immunology		
I, _____, DOB: _____ Hereby Authorize:		
Organization:	Address:	Fax #:
to release the following information to **OIAAI, 1810 E. Memorial Rd. OKC, OK 73131** **P: 405-607-4333 F: 405-607-4404**		

Information to be shared:			
☐ Progress Notes	☐ Lab. Reports	☐ Skin Test	☐ Office Notes
☐ Diagnosis	☐ Pulmonary Function	☐ Other	☐ All Records

The information may be disclosed for the following purpose:		
☐ Insurance	☐ Continued Treatment	☐ Legal
☐ Representatives Request	☐ Own Request	☐ Other

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my medical records as described above for the purpose listed
- I have the right to withdraw permission for the release of information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive copies of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have been treated for psychological or psychiatric conditions and/or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing my records.
- I understand I cannot restrict information that may have already been shared based on this authorization
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the Privacy Regulation.
- Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature.

Signature of Patient:	Date:
Signature of Representative:	Date: