Norman Endoscopy Center

Authorization For Release of Medical Records

NEC is a HIPAA Compliant Facility

Patient Information

Name: ___________________________________ **Birthdate :** _______________

Address: ___________________________________ **Telephone:** ______________

City: ___________________________________ **State:**______ **Zip:** ____________________

Facility/Persons To Receive Records

Name : _________________________________ **Telephone**_____________

Address: _________________________________ **Fax** _____________

City: _________________________________ **State:**______ **Zip:** ___________________

Norman Endoscopy Center to Release Records

1515 N Porter Ste 100 **Telephone: 405-366-0969**

Norman OK 73071 **Fax : 405-701-3734**

By placing my **INITIALS** in the applicable space next to the type of information, I authorize the Following records to be released:

__________________History and Physical

__________________Procedure Reports

__________________Pathology Reports

By placing my **INITIALS** in the applicable space next to the type of information, I understand and agree that this information will be disclosed.

____________________HIV/AIDS related info

____________________Drug/Alcohol treatment

____________________Mental Health info

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 Date