

**Green Country Ultrasound LLC**

**Authorization for Release of Medical Information**

Address: 5323 S 65th West Ave Tulsa, OK 74107 Phone: (918) 238-7329

Fax: (918) 800-2070

# Patient Information

|  |  |
| --- | --- |
| Full Name |   |
| Date of Birth |  / /  |
| Phone Number |   |
| Email Address |   |
| Address |   |
| City, State, ZIP |   |

**Authorization to Release Medical Information**

I authorize the **release of my medical records** as indicated below.

**I****nformation to be released FROM:**

|  |  |
| --- | --- |
| **Field** | **Response** |
| Name/Facility |  Green Country Ultrasound LLC |
| Address |  5323 S 65th West Ave Tulsa, OK 74107 |
| Phone |  (918) 238-7329 |
| Fax |  (918) 800-2070 |

**Information to be released TO:**

|  |  |
| --- | --- |
| **Field** | **Response** |
| Name/Facility |   |
| Address |   |
| Phone |   |
| Fax |   |

# Type of Information to be released

(Please check all that apply)

* All medical records
* Radiology images and imaging reports

# Purpose of Release

(Select one or more)

* Medical treatment/continuity of care
* Personal use
* Legal purposes
* Insurance
* Other:

# Your Rights

* + I understand I may revoke this authorization in writing at any time.
	+ I understand revocation will not apply to information already released in reliance upon this authorization.
	+ I understand that I am not required to sign this form to receive treatment.

# Signature of Patient or Legal Representative

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_Date: / \_\_\_\_\_\_ / \_\_\_\_

If signed by someone *other than the patient*:

Name: Relationship to Patient: Legal Authority (if applicable):