j0186002Charles C. Carter, MD, DPh, PLLC

Medical Record

Release Authorization

1015 E. Broadway, Suite 102 **CARTER CLINIC**

P.O. Box 575

Altus, OK 73522-0575 “*Healthcare for the*

Phone: (580) 480-1600 *community, by people*

Fax: (580) 480-1601 *who care.”*

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work/Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **I hereby authorize records FROM: B. To be release TO: C. For the purpose of:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: **Charles C. Carter, MD. DPh., PLLC** **\*** Continuity of Care/**Transfer of Care**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_**P.O. Box 575**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \* Self/Personal Copy

City/state/zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip: \_**Altus, OK 73522-0575**\_\_\_\_\_ \* Insurance/Worker’s Comp

Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#: \_**(580)480-1600**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \* Litigation/Disability

Fax#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax#: \_**(580)480-1601**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Office Use Only**

Date Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Processed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prepared By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fees May Apply

$1.00 for the first page, and $0.50 for each subsequent page. Electronic Records are $0.12 per page. Postage may be added at an additional charge.

Date Range \_\_\_**ALL**\_\_\_\_\_\_\_

* Physicians Office Notes
* Immunizations
* Operative/Procedure Reports
* Cardiology/EKG Reports
* Lab/Path Reports
* Radiology/X-Ray/MRI Reports
* **Entire Medical** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I UNDERSTAND AND ACKNOWLEDGE:**

1. This release pertains to all of my medical and mental health records created by and in the possession of the medical or mental health professional named above, including such records created by other medical or mental health professionals that are in the named professional’s possession. If psychiatric information is included in any information to be released to the patient, physician consent for such release must be obtained.
2. I release the entities listed above, their agents, and employees from any liability in connection with the use and disclosure of the protected health information. I further release these entities, their agents, and employees from the responsibility for any deleterious effect the review of my medical and/or mental health records may have upon me or others both now and in the future. I personally accept all responsibility for my own distribution and interpretations of medical information contained therein and hold blameless Charles C. Carter, MD, DPh, PLLC for conclusions or opinions drawn from said records without professional knowledge, assistance, or review. I acknowledge that by any personal acceptance of medical records, I am accepting responsibility for the protection of my own right of medical record confidentiality.
3. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the Privacy Rule.
4. **I understand the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, disease such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus also known as Acquired Immune Deficiency Syndrome (AIDS).**

I further understand and acknowledge that this release of medical/mental health records will automatically expire six (6) months from the signature date below. I further acknowledge that I have the right to revoke this release at any time by providing the possessor of my records notice of such revocation in writing. The revocation will apply only to any possible release of records after the records possessor receives the written notice.

With this knowledge, I give my authorization to release of all information requested above, including any information concerning my identity, and release Charles C. Carter, MD, DPh, PLLC, agents, and employees, from any liability in connection with the release of the information contained therein.

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**Patient/Guardian Signature Date**