Matthew R. Stanfield, M.D.

NEUROLOGICAL SURGERY

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name:_____
Social Security #:_____
Patient Address:_____
Patient Phone #:_____
Date of Birth:_____

I hereby authorize Matthew R. Stanfield MD PC to release the following information to Person/Organization Receiving Protected Health Information (PHI):

Name, Address, Phone and fax

_____
_____
_____

Information to be shared:

- ☐ Records for the dates of service between _____and_____
- ☐ Entire Medical Record (includes all records except Psychotherapy Notes)
- ☐ Pertinent Information
- ☐ Imaging reports
- ☐ Operative/Discharge reports

Other:_____

The information may be disclosed for the following purpose(s) only:

☐ Insurance ☐ Continued treatment ☐ Legal ☐ At my or my representatives request

Other:_____

I understand that by voluntarily signing this authorization:

*I authorize the use or disclosure of my PHI as described above for the purpose(s) listed

*I have the right to withdraw permission for the release of my 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 a copy of this authorization.

5500 N. Portland Avenue, Oklahoma City, OK 73112
Office: 405-949-1800 Fax: 405-949-1801

Matthew R. Stanfield, M.D.
NEUROLOGICAL SURGERY

*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 payments 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 or have been treated for psychological or psychiatric conditions or substance abuse.

*I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.

*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 redisclosure 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 or upon the occurrence of following event:

_____	_____
Signature of Patient or Legal Representative	Date
_____	_____
Print Patient or Legal Representative	Expiration date (if longer than one year from date of signature or no event is indicated)
_____	
Description of Legal Representative's Authority	

5500 N. Portland Avenue, Oklahoma City, OK 73112
Office: 405-949-1800 Fax: 405-949-1801