YUKON PEDIATRICS
ALECIA A. HANES, M.D. FAAP

508 W. Vandament, Ste. 210 Yukon, OK 73099
Ph: 405-350-0200 Fax: 405-350-0024

PATIENT REQUEST FOR PROTECTED INFORMATION TO ALECIA A. HANES, M.D.

Patient Name: ______________________________________Patient DOB: ________________

Previous Doctor's Phone ______________________ Fax Number: ______________________

This authorization permits (**Previous Doctor's name/Clinic**) ________________________to use or disclose certain protected health information (PHI) about my child to: **ALECIA A. HANES, M.D. -** the following information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.

All Medical Records

Purpose of Request: ____

By voluntarily signing this authorization, I understand that: *The information authorized for release may include records that may indicate the presence of a communicable or non-communicable disease, including but not limited to diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus know as Acquired Immune Deficiency Syndrome (AIDS).*

A single authorization form may not be used to authorize the release of Psychotherapy Notes and other medical records. A separate form is required for Psychotherapy Notes.

I may revoke this authorization at any time by providing written revocation to the address at the top of this form. My revocation will not apply to information already retained, used, or disclosed in response to this authorization. Unless sooner revoked, the automatic expiration date of this authorization will be twelve (12) months from the date of signature.

Unless 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. The covered entity may not condition treatment based on whether the individual signs the 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.

Print name of Natural Parent/Guardian/Patient: _______________________________________
Describe Relationship to Patient: ____
Address: ____
Phone: ____________________________________

I hereby certify that I have legal authority under applicable law to make this request on behalf of the patient identified above.

Signature of Natural Parent/Guardian/Patient: ____
Date: _______________________________