Crystal Sparling, MD Ashley Yates, MD
865 East Veterans Memorial Hwy
Blanchard, OK 73010

REQUEST FOR MEDICAL RECORDS

Patient Name:_____ Date of Birth:_____

Parent Name/Legal Guardian:_____

Address:_____

Home Phone:_____

I hereby request access to the protected health information in my child's health record. Please send/fax my child's entire health record. I understand:

- I may void this authorization at any time, in writing. My void will not apply to information already retained, used or disclosed in response to this authorization.
- Unless the purpose of this authorization is to determine payment of claim or benefits, Scissortail Pediatrics may not use this as a cause of change in the provision of treatment or payment for the care of my child on my signing of this authorization.
- Information used or disclosed under this authorization may be subject to re-disclosure by the recipient and no longer protected by the federal privacy regulations.
- The information authorized for release also may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below I specifically authorize any such records included in my child's health information to be released.
- The information authorized for release may include information which may indicate the presence of a communicable disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency virus also known as acquired immune deficiency syndrome (AIDS).

Records From: **Address:** **Phone:** **Fax:**	**Records To:** Scissortail Pediatrics **Address**: 865 East Veterans Memorial Hwy Blanchard, OK 73010 **Phone:** 405-342-0388 **Fax:** 888-972-3790

Signature of Parent or Legally Authorized Representative Relationship Date