**Darren Goff, M.D., F.A.C.O.G.**
**Women's Health Care**
4140 W. Memorial Road, Suite 215, Oklahoma City, OK 73120
Phone: 405.242.4030 Fax: 405.242.4031

**REQUEST FOR AN INDIVIDUAL'S HEALTH INFORMATION**

Last: First: Middle: Date of Birth:
Other Names Used: SSN:
Address:
City/State/Zip:
Home Phone: ( ) Work Phone: ( ) Cell Phone: ( )

**Disclose the following protected health information:**

___ Laboratory results ___ Ultrasound records ___ Postnatal history
___ X-Ray ___ Pharmacy information ___ Operative report
___ Pathology ___ Prenatal history ___ Post-op report
___ Other

**Health information or records from:**

Name: Darren Goff, M.D.
Address: 4140 W. Memorial Rd, Ste. 215
City/State/Zip: Oklahoma City, OK 73120
Phone: (405) 242-4030 Fax: (405) 242-4031

**Mail/Fax copies of records or release info to:**

Name:
Circle one: Hosp. Phys. Spouse Family Other
Address:
City/State/Zip
Phone:( ) Fax:( )

**Purpose of request:** ___ Patient's request, ___ Dispute, ___Referral, ___ Other_____

I understand:

- I may revoke this authorization at any time, in writing. My revocation will not apply to information already retained, used or disclosed in response to this authorization. Unless revoked, the automatic expiration date will be one (1) year from the date of signature.
- Unless the purpose of this authorization is to determine payment of a claim or benefits, my physician may not condition the provision of treatment or payment for my signing this authorization.
- Information used or disclosed under this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.
- **The information authorized for release may include information which may indicate the presence of a communicable or non-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).**
- The information authorized for release may include protected health information related to mental health and drug/alcohol abuse.
- As a result, by signing below, I specifically authorize any such records included in my health information to be released.
- I understand that if my records are released that I will be charged $1.00 for the first page and $.50 for each subsequent page. (No charge for records released to physicians or insurance companies). These fees have been set by the Oklahoma State Legislature.

_____ _____ _____
Signature of patient/parent/guardian Relation to patient Date