

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:

Mail/Fax copies of records or release info to:

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

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