



South Tulsa Ear Nose & Throat Center, PC  
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Patient or Patient's Guardian Address \_\_\_\_\_  
Patient or Patient's Guardian Phone Number \_\_\_\_\_

By signing below I, \_\_\_\_\_ (patient or patient's guardian) hereby authorize and instruct South Tulsa Ear Nose and Throat to release information and records pertaining to the medical history and present medical status of (patient) to:

\_\_\_\_\_  
\_\_\_\_\_

and any representative or agent of that person, organization or entity. Additionally, I authorize the above persons, organizations or entities to accept a photo copy of this Authorization with the same force and effect as the original and to release the information and records accordingly. This Authorization is to remain in full force and effect until canceled by me in writing. Documents produced or created after this date of this Authorization is signed may likewise be released pursuant to this Authorization.

I fully understand that I am waiving my right to object to the releasing and providing of such information by reason that it is personal or privileged information or on any other grounds, and release any person, organization or institution of and from any liability as a result of providing information pursuant to this Authorization.

I understand that my medical records may contain information that indicates that I have a communicable or venereal disease, which may include but not limited to, diseases such as Hepatitis, syphilis, gonorrhea or the Human Immunodeficiency Virus (HIV), also known as acquired immune deficiency syndrome (AIDS).

**"THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE. "**

It is my further intention that this Authorization supersede and control any rule, regulation or practice of the person, organization or institution to which it is presented that may be more restrictive or limiting in regard to the release of such information.

I understand that the standard fee for copies of my medical records is \$1.00 for the first page and \$.50 for each additional page as well as any postage charges associated with mailing. This will be bill from Healthport who handles our medical records requests.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient or Patient's guardian

**FOR OFFICE USE:**

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