Dr. James Webb & Associates

6550 E 71st St, Ste 200
Tulsa, OK 74133
918.260.9322 Phone
918.794.8702 Fax

James R Webb, Jr. M.D. **Amanda Robison, APRN CNP**

In order for the James R Webb, Jr. MD PC to provide you with the best possible care, we may require copies of your medical records. For us to obtain this information, we will need written permission. Please review the Authorization and Consent for Release of Medical Records below. Your signature on this form will allow us to obtain the necessary information.

AUTHORIZATION AND CONSENT FOR RELEASE OF MEDICAL RECORDS

Being competent, eighteen (18) years of age or older and duly authorized; do willfully and voluntarily authorize the release of all medical records and information to the Osteoporosis Institute.

I understand and acknowledge the information authorized for release may include information which may be considered a communicable or venereal disease which may or may not include, but are not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea, and Human Immunodeficiency Virus (HIV), also known as Acquired Immune Deficiency Syndrome or "AIDS."

Print Patient Name:____________________________________ Date Signed:________________________

Authorized Signature:__________________________________ Date of Birth:________________________

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AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

Patient Name:______________________________ Medical Record #:__________________

Date of Birth:______________________________ Social Security #:__________________

I hereby authorize James R Webb, Jr. M.D. P.C. to release the following information to:

____
Name of Person/Organization Receiving PHI

____
Name of Person/Organization Receiving PHI

____
Name of Person/Organization Receiving PHI

____
Name of Person/Organization Receiving PHI

Information to be shared:

☐ Entire Medical Record ☐ Lab Results ☐ Imaging Reports ☐ All Billing Information

The information may be disclosed for the following purpose(s) only:

☐ At my or my representative's request ☐ Continued Treatment

☐ Insurance ☐ Legal

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I understand that unless the purpose of 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.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this 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.

____________________________________ ______________________
Signature of Patient or Legal Representative Date

____________________________________ ______________________
Description of Legal Representative's Authority Expiration Date (if longer than one year from date of signature)