



12142 S Yukon Avenue  
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## Authorization for Disclosure of Health Information

Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure:  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

|   |  |
|---|--|
| <input checked="" type="checkbox"/> Complete health records | <input type="checkbox"/> Lab results/X-ray reports |
| <input type="checkbox"/> Physical exam                      | <input type="checkbox"/> Consultation reports      |
| <input type="checkbox"/> Immunization record                | <input type="checkbox"/> Other: _____              |

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization.

**Revolution Health & Wellness Clinic & Transformation Health**  
**12142 S Yukon Avenue**  
**Glenpool, OK 74033**

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE NOTE:** This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC – 3701.243) and federal law 42 CFR, part II.