OXMOOR MEDICAL GROUP
BECAUSE PEOPLE MATTER

AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

☐ **I DO NOT** wish to have test results or other medical information released to any person other than myself.

☐ **I DO** wish to have test results or other medical information released to the people listed below.

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

It is the responsibility of the patient to notify this office of any changes to the above information. If changes do occur, the patient must file another Authorization for Release of Patient information with this clinic. It may be necessary for us to disclose some or all of the information contained in your medical records to other physicians, nurses, and/or healthcare providers (collectively referred to as "providers"). At times, other providers may assist in assessing a patient's condition, screening for potential problems, or providing consultation. All healthcare providers are required by law to maintain your patient confidentiality.

Also, due to the increased awareness of quality care and outcome measurements, it may be necessary to disclose information regarding your care to healthcare agencies (private and/or governmental), your insurance company, and/or your self-insured employer. Beyond information needed to verify your insurance coverage, the data released to your employer will be statistical information only.

Patient Signature _____ Date _____

Patient Name _____ SSN _____