***** Please complete ONLY if you have been seen by another doctor or you have been examined at the emergency room**

OKLAHOMA INJURY CARE

James E. Lynch, M.D.
Heather Hedrick, APRN-CNP
Carrie Galyon, P.T.
Traci Lambert, APRN
Gary Seymour, APRN
Ron D. Somerville, D.C.

Mailing: PO Box 14740 OKC, OK 73113
N: 200 W. Britton Rd, OKC, OK 73114
Phone: 405-755-8000 Fax: 405-755-8001
S: 7825 S. Walker Ave., OKC, OK 73139
Phone: 405-634-1700 Fax: 405-634-1708

Release of Medical Records

I hereby authorize ____

(Physician, Hospital, School, Etc.)

____

(Street Address) (City) (Zip)

To release information from my medical, educational, psychiatric/drug/alcohol records

Specifically:

____ All Records	____ Nursing Notes	____Orders
____ History & Physical	____ Social Serv. Notes	____ Radiology
____ Operative Reports	____ Progress Notes	____ Laboratory
____ Discharge Summary	____ EEG/EKG	____ MRI/ CT Scan

____ Other (Please Specify) ______________________________

From the time period of ____________________ to ______________________.

For the following purpose: ____

This information may be released to ______________________________

____

____

I understand that the specific type of information to be disclosed may include a history of drug, alcohol, mental health treatment, or communicable disease (IE: AIDS/ HIV/ Hepatitis). I expressly understand and agree that no legal responsibility of any nature shall attach to the attending physician or employee in acting upon this authorization. I understand that I may revoke this content at anytime except to the extent that action has been taken in reliance on it and that in any event this content shall expire 90 (ninety) days of patient discharge, unless another date is specified:

(Specification of date or event upon which this consent expires): ____________________

A photocopy or facsimile of this authorization shall be as effective as an original.

____________________________	____________________________
(Date)	(Signature of Patient)
____________________________	____________________________
(Print Patient's Full Name)	(Signature of Spouse, Parent, or Guardian)
____________________________	____________________________
(Date of Birth)	(Relationship)
_____ Male ______ Female	____________________________
	(Witness Signature)