A Chance To Change
2113 W Britton Road
Oklahoma City, OK 73120
(405) 840-9000 | (405) 840-9017

Medical Records: Authorization to Release Protected Health Information (PHI)

A Chance To Change Client Name: _____
Social Security Number: _____
Date of Birth: _____/_____/_____

By completing and submitting this request form, I understand that I am consenting to pay the Medical Records Release fee of $25, and any additional fees related to the release (such as a per-page fee of $0.30). I also understand that these fees must be paid in full prior to the completion of this request.

Hereby Authorize:		**To Release To:**	
Name of Agency:	A Chance To Change	**Name of agency and/or person:**	_____
Address:	2113 W Britton Rd. Oklahoma City, OK 73120	**Address:**	_____ _____
Phone Number:	(405) 840-9000	**Email Address: (optional)**	_____@_____.___
Fax Number:	(405) 840-9017	**Phone Number:**	(____) _____-_____

Dates of Release (MM/YYYY):
Start Date: ___/_____ End Date: ___/_____ Or □ Include Entirety of Record

Purpose of Request:
□ Care Coordination □Release Medical Records □ Obtain Medical Records
□ Other: _____

Method of Release:
□ Paper
□ Email

I understand that information in my A Chance To Change Medical Records 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.

I understand that I can change this authorization at any time. I understand that I must change this authorization in writing to A Chance To Change. I understand that information may have already been released based on this authorization. Unless changed, this authorization will expire on the following date: ___/___/_____. If submitted without a date, this authorization will expire in one (1) year.

I understand that signing this release is voluntary, and a refusal to sign does not affect my receiving services at A Chance To Change. I may inspect or obtain a copy of the information to be released. I also understand that this request may be denied per 45 CFR 164.524(a)(2)-(4). Under penalty of law, I represent that I am, in fact, the undersigned, or his/her legal representative.

Signature of Client or Legal Representative:
Signed Name: _____ Date: ___/___/_____
Print Name: _____ Relationship to Client: _____

Signature of Witness
Signed Name: _____ Date: ___/___/_____