Jordan Orthopedic Clinic
1201 S, Douglas, Suite H, Midwest City, OK 73 130
Phone 405-732-7777 * Fax 405-610-7785

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name:____

Maiden/Previous Name(s)____

Birth Date:____________________Social Security Number:_____________________________________

The undersigned hereby authorizes the release of information

To:

Dr. Christopher Jordan, MD
1201 Douglas Blvd Ste H
Midwest City, OK 73130

From:

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____

Information to be released includes (check all that apply):

_____Complete Health Record

_____History and Physical Exam

______Procedure Report

_____Laboratory Test Results

_____Progress/Office Notes

_____Other Test Results/Reports

The information authorized for release may include records, which may include the presence of a communicable or venereal disease, which may include, but are not limited to disease such as hepatitis, syphilis, gonorrhoea, and human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

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Patient/Legal Representative

Date: