This form is fillable. Click in Name of Patient to begin.

C|S|O
CRAIG & STREIGHT

(405) 321-1926

NORMAN OFFICE
706 24th Avenue NW
Norman, OK 73069

MUSTANG OFFICE
1476 N. Mustang Rd.
Mustang, OK 73064

SOUTH OKC OFFICE
10001 S Penn Ave Suite 130
Oklahoma City, OK 73159

AUTHORIZATION OF RELEASE OF INFORMATION TO FAMILY AND/OR FRIENDS

NAME OF PATIENT	DATE OF BIRTH

I authorize Craig & Streight Orthodontics to release protected health information to the entities named below:

NAME	RELATIONSHIP	FINANCIAL INFO	MEDICAL INFO
		◯YES ◯NO	◯YES ◯NO
		◯YES ◯NO	◯YES ◯NO
		◯YES ◯NO	◯YES ◯NO
		◯YES ◯NO	◯YES ◯NO
		◯YES ◯NO	◯YES ◯NO
		◯YES ◯NO	◯YES ◯NO
		◯YES ◯NO	◯YES ◯NO
		◯YES ◯NO	◯YES ◯NO
		◯YES ◯NO	◯YES ◯NO

PLEASE LIST ANY RESTRICTIONS REGARDING INFORMATION TO BE RELEASED

I understand that I have the right to revoke this authorization, in writing , at any time. I understand that a revocation is not effective in cases where the information has already been disclosed, but will be effective immediately upon receipt of the notification by the Practice. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand I have the right to refuse to sign this authorization. This authorization shall be in force and effect until revoked by the patient or representatives signing the authorization.

SIGNATURE OR PERSONAL REPRESENTATIVE

DATE

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

You can submit the file by emailing the file to admin@craigandstreight.com or print it and bring it with you to your initial consultation.

By sending this form via email, I'm aware that information are not encrypted. I understand the risks of unencrypted email.