AUTHORIZATION TO OBTAIN HEALTH CARE INFORMATION

Patient's Name: ______________________________ Previous Name: ______________________________

Date of Birth: ______________________________ Social Security Nbr: ______________________________

I request and authorize: Optimal Health
Office of Noel R. Williams, M.D.
9800 Broadway Ext. #200
OKC, OK 73114

To obtain health information from the physician/entity listed below:

Name/Address	Phone Number	Relationship

☐ Complete health record ☐ Laboratory Test Results ☐ X-Ray Report ☐ Billing Record

☐ Other ____________________

By state law, you must be advised, The information authorized for release may include records, which may indicate the presence of a communicable or venereal disease which may include; but not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus also known as Acquired Immune Deficiency Syndrome (AIDS)

______________________________ ______________________________
Signature of patient or patients authorized representative Date

______________________________ ______________________________
Relationship or status if signed by anyone other than the patient,
Parent, legal guardian, personal representative, etc. Date

This authorization shall remain in effect until notice of revocation is received by Dr. Noel R. Williams at the above address.