AIRWAY HEALTH & TONGUE TIE CENTER
of OKLAHOMA

# HIPAA Release Form

Oftentimes it is necessary to obtain your complete medical history in order to devise a treatment plan that will properly address all of your immediate and long terms medical needs. This consent gives our office permission to obtain those records on your (or your dependents) behalf.

Patient Name: _____ Date of Birth: _____

Previous Doctor/Doctor's Office Name: _____
Address: _____
City: _____ State: _____ Zip: _____

I authorize Airway Health and Tongue Tie Center of Oklahoma to request and receive any and all previous medical charting as they pertain to the above named patients medical health and treatment.

_____ DOB: _____/_____/_____
Print Name of Patient or Legal Guardian

_____ _____
Signature of Patient or Legal Guardian Date

All patients over the age of 18 ***MUST*** sign their own forms. Patients under the age of 18 ***CANNOT*** sign for themselves. ***ONLY*** a parent or ***legal*** guardian may sign for a patient under the age of 18.