OKLAHOMA STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

I. INDIVIDUAL INFORMATION (FOR PERSON WHOSE INFORMATION WILL BE SHARED)

Name _____ Date of Birth _____

Address _____ City _____

Area Code & Telephone Number _____ State _____ Zip _____

II. SCOPE & PURPOSE FOR SHARING INFORMATION

I understand protected health information is information that identifies me. The purpose of this authorization is to allow _____ to share my protected health information.

III. AUTHORIZATION & INFORMATION TO BE SHARED

I authorize _____ as set forth below, to share my protected health information for reasons in addition to those already permitted by law.

A. Person/Organization Receiving Information and Purpose for Sharing

Persons/Organizations Authorized to Receive My Information (Name, Address, Phone & Fax)	Relationship	Purpose

B. Information to be Shared

1. Check one or more boxes below.

☐ Psychotherapy Notes (if checking this box, no other boxes may be checked)
☐ Mental Health Records
☐ Entire Medical Record (includes all records except Psychotherapy Notes)

☐ Pathology Report	☐ History and Physical	☐ Operation Report(s)
☐ Progress Notes	☐ Consultation Report(s)	☐ Discharge Summary
☐ EKG Report(s)	☐ Laboratory Report(s)	☐ Radiology Report(s)
☐ Physician's Orders	☐ Radiology Films	☐ Alcohol or Drug Abuse Records

☐ Other _____

2. Covering Services Between _____ and _____ (Insert either date(s) or "all.")

IV. EXPIRATION & REVOCATION

A. This Authorization will Expire (must choose one):

☐ 12 months from the date signed in Part V.B. ☐ Other (insert date or event): _____

B. Right to Revoke
I understand I may change this authorization at any time by writing to the address listed at the bottom of this form. I understand I cannot restrict information that may have already been shared based on this authorization.

V. ACKNOWLEDGEMENTS & SIGNATURES

A. Acknowledgements

1. I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.

2. ☐ If checked and initialed, is authorized to share my protected health information for the purpose of marketing. I understand may receive either direct or indirect compensation for sharing my information in this case. Individual initials _____

3. I understand if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information.

4. I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request to the address listed at the bottom of the form.

5. I acknowledge information authorized for release may include records, which may indicate the presence of a communicable or noncommunicable disease.

B. Signature

This document must be signed by the individual or the individual's legal representative.

Signature (Patient or Legal Representative) Date

Printed Patient or Legal Representative Name Capacity of Legal Representative (if applicable)

Company Address:

The following information may only be completed by

☐ If checked by — disclosure of Alcohol or Drug Abuse Records is subject to the following restrictions under 42 C.F.R. Part 2:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.