INTEGRIS HEALTH

Authorization to Use or Share Protected Health Information (PHI)

*Patient Name: _______________________________________ Medical Record #: _____________________________

Patient Address: ______________________________________ Social Security #: ______________________________

*Date of Birth: ____ Patient Phone #: ______________________________

*I hereby authorize____
Name of Person/Organization Disclosing PHI

To release the following information to Person/Organization Receiving PHI:

*Name, Address, Phone, and Fax	*Relationship	*Purpose

***Information to be shared:**

__ Records for dates of service between ____________ and ____________
__ Psychotherapy Notes (if checking this box, no other boxes may be checked)
__ Entire Medical Record (includes all records except Psychotherapy Notes)
__ Pertinent Information
__ Mental Health Records
__ STD Records
__ HIV Records
__ Substance Abuse Records
__ Billing Information

Other: ____

The information may be disclosed for the following purposes(s) only:
__ Insurance __ Continued Treatment __ Legal __ At my or my representative's request

Other:____

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.

HIM ROI Authorization

INTEGRIS HEALTH

- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following event:

____

*_____________________________________ *_____________________________________
Signature of Patient or Legal Representative Date

*_____________________________________ *_____________________________________
Print Patient or Legal Representative Expiration date (if longer than one year from date of signature or no event is indicated)

*______________________________
Description of Legal Representative's Authority

**Required field*

(INTERNAL USE ONLY)

1) Number of pages released: _____

2) If releasing records other than what is requested on the authorization, please specify reason below:

____

____

Specific documentation released:
a. Pertinent Only ____

b. Other ____

3) Staff initials: ____

4) Verification of authorized receiver:
a. License ____
b. Photo ID ____
c. Other ___________________________

5) Authorized Receiver:
a. Name: ____

b. Signature: ________________________ Date: _____________

HIM ROI Authorization

INTEGRIS HEALTH

Title

Instructions for ……..

1. Indicate patient name and date of birth.
2. OPTIONAL: Indicate Medical Record # and/or Social Security #.
3. Indicate the name of person/organization disclosing PHI.
4. Indicate the name and address of person/organization receiving PHI.

Information to be shared:

1. Check the appropriate box.
2. If the information to be shard is not listed, check the "other" box and indicate what information is to be shared in the space provided.
   a. If billing information is shared, indicate which billing information is requested. If all billing information is requested, just check the box.
   b. If psychotherapy notes are requested, no other information can be shared. A separate Authorization must be completed for additional information

Purpose for disclosing information:

1. Check the appropriate box.
2. If the purpose is not listed, check the "other" box and indicate the purpose in the space provided.

Expiration Date:

1. Unless otherwise indicated at the bottom of the form, the expiration date is one year from the date of the patient's signature or upon the occurrence **or** an event chosen by the individual.
   a. If the patient chooses an event, list the event in the space provided.
   b. If the patient chooses to make the expiration date longer than one3 year, indicate in the space provided at the bottom of the form.

Signature:

1. Obtain the signature of the patient or Legal Representative
2. If a Legal Representative signs the form, indicate the description of the Legal Representative's authority.

Date:

1. The date is the date the form is signed.