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 as set forth below, 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)
☐ Entire Medical Record (includes all records except Psychotherapy Notes)
☐ Mental Health Records
☐ Alcohol or Drug Abuse Records
☐ HIV Records
☐ STD Records
☐ Progress Notes
☐ Medical Images
☐ Radiology Report(s)
☐ Cardiology Report(s)
☐ History and Physical
☐ Operation Reports
☐ Consultation Report(s)
☐ Pathology Reports
☐ Discharge Summary
☐ Physician's Orders
☐ Laboratory Report(s)

☐ Other_____

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

III. EXPIRATION & REVOCATION

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

☐ 12 months from the date signed in Part IV.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.

IV. ACKNOLEDGEMENTS & 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.

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)

Address of entity authorized to release information:_____

The following information is for administrative purposes and may only be completed by an entity that is a "Program" under 42 C.F.R. Part 2 with respect to alcohol and drug abuse records.

☐ If checked — 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.

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

PATIENT INSTRUCTIONS

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

Write your name, date of birth, complete address, area code and telephone number in the spaces provided.

II. SCOPE & PURPOSE FOR SHARING INFORMATION

This section explains what protected health information is and lets you know that you are allowing your protected health information to be shared with the person (s) you name in Section II A.

A. Person/Organization Receiving Information and Purpose for Sharing

Write the person/organization's name you wish to share information with, their address, phone number and fax number, their relationship to you (example: lawyer, family member, etc.), and the purpose for which you wish to share the information. **If you write more than one person/organization in this section, the information you check in Section B will be shared with everyone listed.**

B. (1) This section lists what information you want to share. You can check one or more boxes, **unless** you are sharing psychotherapy notes. If you are sharing psychotherapy notes, you can only check that box and no others.

(2) List the dates of service for the information you want to share (if you don't know the exact dates, try to at least give the month and year), or you can choose to share all your records by writing the word "all".

III. EXPIRATION & REVOCATION

A. Expiration

By law, your permission to share information can only last for a certain amount of time. You must check one box.

B. Right to Revoke

You can change your mind about sharing this information at any time. If you change your mind, you must write to the address listed under your signature in Section IV.B and ask that your information no longer be shared. Information may already have been shared before your written request is received.

IV. ACKNOWLEDGEMENTS & SIGNATURES

A. Acknowledgements

1. This section explains that you voluntarily signed the form and that you can't be denied eligibility for benefits, treatment, enrollment, or payment of claims if you don't sign the form.

2. If you check the box and write your initials in this section, you are agreeing to share your protected health information for marketing purposes. The person/company asking you to sign the form may receive some sort of payment for your information.

3. If you give permission to share your protected health information with someone who is not a health plan or health care provider, (family member, etc) privacy regulations may no longer protect the information.

4. You may look at or get a copy of the protected health information shared under this form by writing to the address listed under your signature in Section IV.

B. Signature - Sign and date the form in the spaces provided.

If you are agreeing to share alcohol or drug abuse records, law protects that information in certain instances. If the box under your signature is checked, the person or organization receiving your alcohol or drug abuse records under this authorization may not be able to share this information without your written permission.

The last paragraph under the gray-shaded box is for the physician/provider use only.