



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

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

Name	Date of Birth
Address	City
Area Code & Telephone #	State Zip

2. SCOPE AND PURPOSE FOR SHARING INFORMATION

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

(Name of Institution, organization, hospital and/or doctor)

(address, phone and/or fax)

to share my protected information.

3. 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

(Name, Address, Phone & Fax)	Relationship	Purpose
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

b. Information to be Shared (check one or more boxes below)

- *Entire Medical Record History & Physical Operative Report(s) Consultation Report(s)
- Progress Notes Discharge Summary EKG Report(s) Physician Orders
- Pathology Report Lab Report(s) Radiology Report(s) Radiology Films
- Mental Health Records Alcohol or Drug Abuse Records
- Psychotherapy Notes (if checking this box, no other boxes may be checked)
- Other _____

*Entire Medical Record includes all records except Psychotherapy Notes

c. Covering Services Between _____ and _____ (insert either date(s) or "all")

4. EXPIRATION & REVOCATION

a. This Authorization will Expire (must choose one)

12 months from the date signed in Part 5B 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.

c. 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 _____.

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

e. 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.

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

5. 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)

Witness to the signature

Health and Wellness Center
Stigler
1505 East Main, Suite A
Stigler, OK 74462
Phone: 918-967-3368
Fax: 918-967-3351

Health and Wellness Center
Eufaula
17 Hospital Drive
Eufaula, OK 74432
Phone: 918-689-3333
Fax: 918-689-3330

Health and Wellness Center
Sallisaw
1630 S. Kerr Blvd.
Sallisaw, OK 74955
Phone: 918-790-2653
Fax: 918-790-2763

The following information may only be completed by The Health and Wellness Centers

If checked by _____ - disclosure of Alcohol or Drug Abuse Records is subject to the following restrictions under 42 C.R.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.

Office Use Only:

Records were:

Mailed to recipient on _____ Faxed to recipient on _____ Hand Delivered to recipient on _____