

# AUTHORIZATION FOR ACCESS BY PATIENT OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Release of Medical Records)

Patient's Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security No.: \_\_\_\_-\_\_\_\_-\_\_\_\_

I hereby authorize the use or disclosure of the Protected Health Information (PHI) described below to be provided to or obtained by the following:

Name of Individual/Facility/Company to Receive PHI: \_\_\_\_\_

Address: \_\_\_\_\_

City, State: \_\_\_\_\_

Phone No.: \_\_\_\_\_

Fax No: \_\_\_\_\_

Name of Individual/Facility/Company to Disclose PHI: \_\_\_\_\_

Ada Outpatient Clinic

Address: 2901 Arlington St.

City, State: Ada, OK 74820

Phone No.: (580) 332-8900

Fax No: (580) 332-9052

Portions to Release are:  Face Sheet  History and Physical  Doctor's Progress Notes  Discharge Summary  
 Lab/ X-ray  EKG/ Echo  Stress Test Report  Complete Record

OTHER (Specify) \_\_\_\_\_

DATE(S) OF SERVICE: \_\_\_\_\_ THROUGH \_\_\_\_\_

The information will be obtained, used, or disclosed for the following purpose(s) only:

Insurance  Continued treatment  Legal  At the request of the patient or patient's representative

Other (Specify) \_\_\_\_\_

### I understand:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Practices. Unless revoked or otherwise indicated, the automatic expiration date will be one year from the date of signature or upon occurrence of the following event: \_\_\_\_\_
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information covered by this authorization. The entity authorized to disclose the information will not be compensated by the recipient for the disclosure, except for the cost of copying and mailing as authorized by law.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- I have the right to inspect the health information to be released and I may refuse to sign this authorization.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment or payment for my care on my signing this authorization.

**I understand that my medical information may indicate that I have a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, the Human Immunodeficiency Virus (HIV), or Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.**

### THIS BOX FOR WORKER'S COMPENSATION ONLY

*"I authorize Ada Outpatient Clinic to release information contained in its clinical records to the Worker's Compensation Insurance Carrier concerning the diagnosis, treatment, and prognosis of the undersigned patient. The records may also be used for any matter involved in the workers' compensation claim, including proof medical bills incurred for the treatment of the patient, filing the claim in Court and furnishing copies to the involved parties."*

Signature of Patient or Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

### Description of Legal Representative's Authority

**NOTICE OF RIGHTS:** Information in your medical record that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court or Department of Health, disclosure among health care providers or disclosure for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court of the Department of Health or by law.

### Expiration Date of Authorization