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

Name | **Date of Birth** | **Social Security #**

Address | **Phone number**

I hereby authorize _____
Name and Address of Person/Organization Disclosing PHI

to release the following information to _____
Name and Address of Person/Organization Receiving PHI

Information to be shared:

☐ Psychotherapy Notes (if checking this box, no other boxes may be checked)

☐ Entire Medical Record ☐ Mental Health Records ☐ Substance Abuse Records

☐ Medical information compiled between _____ and _____

☐ Billing Information for _____

☐ Other: _____

The information may be disclosed for the following purpose(s) only:

☐ Insurance ☐ Continued Treatment ☐ Legal ☐ At my or my representative's request

☐ Is this request related to an investigation or legal process regarding reproductive health care? (**Attestation Form Needed**)

☐ 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.
- 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.
- I understand that my information may not be secure once it leaves the Tulsa Health Department. The Tulsa Health Department is not responsible for the protection of my information after sending to me as requested.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature.

Signature of Patient or Legal Representative | **Date**

Description of Legal Representative's Authority | **Expiration Date** (if longer than one year from date of signature or no event indicated)