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

STIGLER HEALTH AND WELLNESS CENTER, INC RELEASE OF INFORMATION (ROI)

Patient Name: _____	Medical Record # _____
Date of Birth:_____	Social Security #: _____

I hereby authorize _____
Name of Person/Organization Disclosing PHI

to release the following information to _____
Persons/Organizations Authorized to Receive My Information

Address	Relationship	Phone	Fax/Email
_____		_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____

Information to be shared:

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

☐ Psychiatric Medication Management Notes ☐ Behavioral Health Assessment

☐ Substance Use Disorder 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

☐ 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.
- 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.
- I understand that my records are currently protected by Oklahoma State Statutes and federal privacy regulations

including the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164. I understand that my health information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may redisclose the information and it may no longer be protected by the HIPAA privacy law. When applicable, the federal regulations governing the confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, prohibits redisclosure of such information without my specific written consent or when permitted by such regulations.

- **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

EXPIRATION & REVOCATION:

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

_____ _____

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

_____

Employee Completed By:

Mailed _____ **Faxed** _____ **Hand Delivered** _____ **Emailed** _____

Instructions for Oklahoma Standard Authorization to Use or Share Protected Health Information (PHI)

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 shared 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 of 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 one 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