OKLAHOMA CITY INDIAN CLINIC
www.okcic.com

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name: ____ Other Names Used: ____

Date of Birth: _______________________________ Patient Phone: ________________________________ Health Record #_______________

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:

Name/Facility: ____

Address: ____

City, State: ____

Name of Individual/Facility to Disclose PHI:

Name/Facility: ____

Address: ____

City, State: ____

Dates of treatment to be released:

____

Information to be disclosed from my health record:

- ❑ Complete Record (specify):_________________________
- ❑ Lab Reports____
- ❑ Radiology Reports _______________________________
- ❑ EKG
- ❑ Other (specify content and date): ____________________ ____

If you would like any of the following sensitive information disclosed, check the applicable box (s) below.

- ❑ Alcohol/Drug Abuse Treatment/Referral
- ❑ Mental Health (other than Psychotherapy Notes)
- ❑ Sexually Transmitted Diseases
- ❑ HIV/AIDS-related Treatment
- ❑ Psychotherapy Notes ONLY (may **ONLY** be released to another mental health professional)
  By checking this box, I waive my psychotherapist-patient privilege to the notes.

PURPOSE OF DISCLOSURE:

☐ Continued Care ☐ Consultation ☐ Insurance ☐ School ☐ Research ☐ Disability

☐ At the request of the patient or patient's representative

☐ Legal (specify): ____

☐ Other (specify): ____

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 re-disclosure by the recipient and no longer be protected by privacy regulations.
- Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature.

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 the 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.

☐ Recipient above will pick up copies of my records(expected date):__________ ☐ Mail copies of my records to the Recipient's address above

☐ Fax my records to the Recipient: (____) ___________________ ☐ Other (if available): _________________________________

☐ I understand the security of email cannot be guaranteed and that unauthorized individuals may be able to access the message. I understand the information sent via electronic communication may include information that may indicate the presence of a communicable disease or non-communicable disease, mental health records, or substance use disorder records. It is my responsibility to notify OKCIC if the email address information changes after submitting this form. **I understand and agree to the statements above and wish to have my records sent to the Recipient via email at: ___________________________________@_______________.**

Signature of Patient: ____ Date:____________________

____ Date:____________________

Signature of Authorized Representative or Witness (If signature is by thumb print or mark)**:**

Relationship to Patient: ☐ Power of Attorney ☐Health Care Proxy ☐Witness ☐Other_______________________________________

A PHOTO IDENTIFICATION WILL BE REQUIRED TO PICK UP MEDICAL RECORDS

- ❑ Patient Verbal Consent
- ❑ Verified Fax

White – Office Copy File Yellow – Patient Copy