OKLAHOMA CITY INDIAN CLINIC

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:_____

Fax: _____

Name of Individual/Facility to Disclose PHI:

Name/Facility: _____

Address:_____

Fax:_____

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

☐ 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.**
- 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 under this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy law. Student treatment/education records may retain continuing privacy protections in accordance with 34 CFR Part 99 (FERPA).
- The information authorized for release may include substance use disorder records. This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). A general authorization for the release of medical or other information is not sufficient for this purpose. As a result, by signing below, I specifically authorize any such records included in my health information to be released. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. The Federal rules prohibit anyone receiving this information or record from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2.
- 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 records(expected date):_____

☐ Fax my records to the Recipient: (____) _____

☐ Mail copies of my records to the Recipient's address above

☐ 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, Signature of Authorized Representative or Witness Relationship to Patient: Power of Attorney Health Care Proxy Witness

Date

Please fax this form to (405) 948-4933 OR email it to him@okcic.com