AUTHORIZATION FOR ACCESS BY PATIENT OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ **Medical Record #:**_____

Date of Birth:_____ **Social Security #:**_____

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

Name/Address of Individual/Facility to Receive PHI:
TULSA OB-GYN, ASSOCIATES, INC.
2000 South Wheeling Avenue, Suite 800
Tulsa, Oklahoma 74104
Phone: 918-747-9641 Fax: 918-746-2252

Name/Address of Individual/Facility to Disclose PHI:
_____
_____
_____
_____

Information authorized for use or disclosure, or obtained:

- ☐ All medical information concerning this patient.
- ☐ Medical information on this patient compiled between_____to _____
- ☐ Only: _____

Dates of treatment if known:_____

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

☐ Insurance ☐ Continued treatment ☐ Legal ☐ At the request of the patient or the 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 redisclosure 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 of 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 authorized for use or disclosure may include information which may indicate the presence of a communicable or non-communicable disease and may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and Human Immunodeficiency Viruses also known as 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.

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

_____ _____
Description of Legal Representative's Authority **Expiration date of Authorization**

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 of the 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 any order of the court, the Department of Health or by law.

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