AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT'S NAME (Please Print)_____

Member I.D. Number_____

I authorize the use and disclosure of my protected health information as described below.

My protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

I understand that my medical information may indicate that I have a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea or the human immunodeficiency virus, also know 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.

OSMA Health is authorized to use or disclose my protected health information.

WHO MAY RECEIVE MY PROTECTED HEALTH INFORMATION
The following individual, organization, or class of persons is authorized to receive my protected health information:

_____
_____

WHAT INFORMATION CAN BE DISCUSSED
The protected health information that may be used and disclosed is as follows. Check any or all of the categories below. Be advised that all information that falls within the selected category(ies) will be disclosed unless limitations are specified.

☐ Enrollment and eligibility. Limitations _____
☐ Claims. Limitations _____
☐ Billing and accounting. Limitations _____
☐ Provider relations. Limitations _____
☐ Medical services, utilization and case management. Limitations_____

_____

WHY DO THEY NEED THIS PROTECTED HEALTH INFORMATION

My protected health information will be used or disclosed for the following purposes(s):

_____

_____

[Describe the reason for each use and disclosure of the protected health information. If an individual initiates the authorization for his or her own purposes, insert "at the request of the individual."]

I understand that if my protected health information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, my protected health information described above may be re-disclosed and no longer protected by privacy regulations.

I understand that I may revoke this authorization at any time by sending a written notification to the Privacy Coordinator, 13439 Broadway Extension Suite 110, Oklahoma City, OK 73114, and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective for information that may have already been used or disclosed, relying on this authorization.

This authorization is effective until ☐ further notice ☐ _____
Specific Date

_____ _____
Signature of Patient making this authorization (if over 18) Date

_____
Printed name of patient

_____ _____
Signature of Guardian or Authorized Representative making this authorization on behalf of the patient Date

_____
Printed name of Guardian or Authorized Representative

Description of signing authority for Guardian or Authorized Representative:

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