

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Date: _____
Health Record Number _____
Date of Birth: _____ SSN: _____

- 1. I authorize the use or disclosure of the above named individual's health information as described below:
- 2. The following individual or organization is authorized to make the disclosure:

Address _____ Fax: _____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- all admission summaries
- all discharge summaries
- ER reports
- psychological evaluations & reports
- laboratory results from (date) _____ to (date) _____
- x-ray and imaging reports from (date) _____ to (date) _____
- surgical reports
- progress reports & narratives (no nurses notes or copies of patients prescriptions)

We are requesting only records dated after _____

- 4. I understand that the information authorized for release may indicate the presence of a communicable or venereal disease which may include but, is not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea or The Human Immunodeficiency Virus (HIV), also known as Acquired Immune Deficiency Syndrome (AIDS). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. **THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE. I further understand that my medical information may indicate that I have or have been treated for psychological conditions or substance abuse.**
- 5. This information may be disclosed to and used by the following individual, my attorney:

RAMONA S. HANSON, ATTORNEY AT LAW
1300 E. 9th Street, Suite 1, Edmond, Oklahoma 73034
(405)330-1849 FAX (405) 330-3418

upon request and at their expense for the purpose of: **Social Security Insurance Disability Claims, Social Security Supplemental Income or Workers' Compensation, or Long Term Disability.**

- 6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.
- 7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact (insert HIM director, privacy officer, or other office or individual's name or contact information).

Signature of Patient or Legal Representative

Date

If Signed by Legal Representative, Relationship to Patient

Signature of Witness

A PHOTOCOPY SHALL HAVE THE SAME EFFECT AS AN ORIGINAL