

# AUTHORIZATION FOR ACCESS FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
DOB

I here by authorize the use or disclosure of the protected health information described below to be provided or obtained by the following:

Name and Address of individual/Facility/Company to Receive PHI

Name and Address of individual/Facility/Company to Disclose PHI

**Premier Family Care PC**

**P.O. Box 140728**

**Broken Arrow, Oklahoma 74014**

**Phone (918) 258-9990 Fax (918) 994-4277**

Information authorized for use or disclosure, or to be obtained:

\_\_\_\_\_ All medical information concerning this patient

\_\_\_\_\_ Medical Information of the patient compiled between \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_ Only \_\_\_\_\_

Date of Treatment if known \_\_\_\_\_

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

\_\_\_\_\_ Insurance

\_\_\_\_\_ Continued treatment

\_\_\_\_\_ Legal

\_\_\_\_\_ At the request of the patient or patient 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 authorization. I may revoke this document by presenting 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.
- 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 Requirement.
- I have the right inspect the health to be released and I may refuse to sign this authorization.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment for my care on my signing this authorization.

Understand that my medical information may indicate that I have a communicable or venereal disease which may include, but is not limited to, disease's such as hepatitis, gonorrhea or the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have been treated for psychological or psychiatric condition or substance abuse.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Legal Representative

\_\_\_\_\_  
Expiration Date of Authorization

NOTICE OF RIGHTS: Information in your medical record that you have or may have communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court of the Department of Health, disclosing 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 the identifying information is authorized by you, by an order of the Department of Health or by law.