AUTHORIZATION FOR ACCESS BY PATIENT 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

Premier Family Care
2440 E 81st Street South
Tulsa, Oklahoma 74137
Phone (918) 477-5190 Fax (918) 477-5199

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

_____

_____

_____

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 of disclosed in response to this authorization. I may revoke this authorization. I may revoked 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 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 disclose of the identifying information is authorized by you, by an order of the Department of Health or by law.