# OKLAHOMA STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

Patient Name:	Medical Record #:
Date of Birth:	Social Security #:
hereby authorize	
Name of Person/0	Organization Disclosing PHI
to release the following information to	
Name and Addre	ss of Person/Organization Receiving PHI
Information to be shared:	
☐ Psychotherapy Notes (if checking this box, no other box	es may be checked) □ Entire Medical Record
☐ Billing Information for	
☐ Substance Abuse Records ☐ Medical information com	npiled between and
□ Other:	
The information may be disclosed for the following pur	nosa(s) only:
☐ Insurance ☐ Continued Treatment ☐ Legal ☐	• • • •
□ Other:	
<ul> <li>disclose information, I can revoke this authorization person/organization disclosing the information and disclosed.</li> <li>I have the right to receive a copy of this authorization.</li> <li>I understand that unless the purpose of this authorization this authorization will not affect my eligibility for being this authorization will not affect my eligibility for being the many many indicate that I have a conclude, but is not limited to diseases such as hepathat I have or have been treated for psychological of I understand I may change this authorization at any I understand I cannot restrict information that may he Information used or disclosed pursuant to the authorization be protected by the Privacy Regulation.</li> </ul>	ase of my information. If I sign this authorization to use or at any time. The revocation must be made in writing to the will not affect information that has already been used or on.  Zation is to determine payment of a claim for benefits, signing nefits, treatment, enrollment or payment of claims. Communicable and/or non-communicable disease which may titis, syphilis, gonorrhea or HIV or AIDS and/or may indicate or psychiatric conditions or substance abuse. If time by writing to the person/organization disclosing my PHI. In average already been shared based on this authorization. Or
Signature of Patient or Legal Representative  Description of Legal Representative's Authority	Date  Expiration date (if longer than one year from date of

# Instructions for Oklahoma Standard Authorization to Use or Share Protected Health Information (PHI)

- 1. Indicate patient name and date of birth.
- 2. OPTIONAL: Indicate Medical Record # and/or Social Security #.
- 3. Indicate the name of person/organization disclosing PHI.
- 4. Indicate the name and address of person/organization receiving PHI.

# Information to be shared:

- 1. Check the appropriate box.
- 2. If the information to be shared is not listed, check the "other" box and indicate what information is to be shared in the space provided.
  - a. If billing information is shared, indicate which billing information is requested. If all billing information is requested, just check the box.
  - b. If psychotherapy notes are requested, no other information can be shared. A separate Authorization must be completed for additional information.

# Purpose for disclosing information:

- 1. Check the appropriate box.
- 2. If the purpose is not listed, check the "other" box and indicate the purpose in the space provided.

# **Expiration Date:**

- 1. Unless otherwise indicated at the bottom of the form, the expiration date is one year from the date of the patient's signature <u>or</u> upon the occurrence of an event chosen by the individual.
  - a. If the patient chooses an event, list the event in the space provided.
  - b. If the patient chooses to make the expiration date longer than one year, indicate in the space provided at the bottom of the form.

# Signature:

- 1. Obtain the signature of the patient or Legal Representative
- 2. If a Legal Representative signs the form, indicate the description of the Legal Representative's authority.

#### Date:

1. The date is the date the form is signed.