Mary C. Kirk, MD, PLLC

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME:_____ DATE OF BIRTH: _____

SOCIAL SECURITY #: _____ PHONE #: _____

I hereby authorize the use or disclosure of the Protected Health Information below to be provided to or obtained by the following:

Name/Address/Fax Number of Individual/Facility/Company to Receive PHI	**Name and Address of Individual/Facility to Disclose PHI**
	Dr. Mary C. Kirk 8177 S Harvard Ave., #410, Tulsa, OK 74137 Phone: 918.508.2200 Fax: 918.508.2299

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

☐ Entire Medical Record ☐ Consultation ☐ Progress Notes ☐ Lab reports ☐ Radiology ☐ Hospital Records

☐Other: _____

☐Medical information between _____ to _____

The information will be obtained, used, or disclosed for the **following purpose** only:

☐ Insurance ☐ Continued treatment ☐ Legal ☐ At the request of the patient or patient's representative

☐Other (specify): _____

I understand:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already retained, used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Rights. Unless revoked, the automatic expiration date will be six (6) months from 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. The entity authorized to disclose the information will not be compensated by the recipient for such disclosure. Normal applicable fees, such as copy fees, may apply.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure 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 Requirements.
- 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, payment, enrollment in a health plan, or eligibility for benefits on obtaining this authorization.

I understand that the information authorized for use or disclosure may include information which may indicate the presence of a communicable or non-communicable disease and may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and human immunodeficiency viruses also known 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.

_____ _____

SIGNATURE OF PATIENT DATE

_____ _____

SIGNATURE OF PERSONAL REPRESENTATIVE DATE

_____

DESCRIPTION OF REPRESENTATIVES AUTHORITY TO ACT FOR THE PATIENT

NOTICE OF RIGHTS: Information in your medical records that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court or the Department of Health, disclosure among healthcare providers or for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court or the Department of Health or by law.

Please direct any additional questions to
medicalrecords@kirkobgyn.com