

TULSA FERTILITY CENTER

115 E. 15TH ST.
TULSA, OK 74119

918-584-2870 (PHONE)
918-587-3602 (FAX)

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ Social Security #: _____

DATE OF BIRTH: _____ Medical Record #: _____

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

Name and Address of Individual/Facility/Company to **RECEIVE** PHI Name and Address of Individual/Facility to **DISCLOSE** PHI

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

- History & Physical Discharge Summary Operative Report ER Record Consultation Lab Reports Progress Notes
 X-ray Reports Vaccination Records _____ Complete Medical 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) _____

Oklahoma state law allows us to charge \$1.00 for the first page and \$.50 for each additional page for copies of medical records. There is not a charge for medical records sent directly to a physician's office via email.

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 twelve (12) 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 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 Requirements.
- I have the right to inspect the health information to be released, unless prohibited by law 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, payment, enrollment in a health plan, or eligibility for benefits on obtaining this authorization.

I understand that the information authorized for release may include records which may indicate the presence of a communicable or noncommunicable disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, 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 of 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.