Oklahoma Surgical Hospital

Authorization to Use or Disclose Health Information

I hereby authorize **Oklahoma Surgical Hospital** to release the following information to:
Name: _____
Complete Address: _____
Patient Email Address: _____ _____

_____ _____ _____
Name of Patient Date of Birth Phone Number

_____
Date of Service

_____
Social Security Number

Purpose: 1. Personal Records _____
2. Further Treatment _____
3. Marketing _____ Remuneration _____
4. Other _____

This authorization will expire on _____(consent date or event) or 6 months after the date of signature.
I UNDERSTAND THAT MY MEDICAL RECORDS MAY CONTAIN INFORMATION THAT INDICATES THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE. THIS MAY INCLUDE BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOW AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

1. The following individual(s) or organization(s) are authorized to make the disclosure:
   _____ _____
2. The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated.)
   - ___ Complete record
   - ___ Pertinent information which includes: Facesheet, Discharge Summary, History & Physical, Physician Orders, Statement of Diagnostic Test Results
   - ___ Lab results
   - ___ X-ray and Imaging Reports (Actual films must be checked out from the Imaging Center)
   - ___ Consultation reports from (please supply doctors' names): _____
   - ___ Imaging CD ($20.00)
   - ___ Operative report
   - ___ Other (please describe): _____
3. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
4. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
5. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.
6. I understand there may be a charge for copies of my records needed for <u>personal use</u>. The cost is $1.00 for the first page and $.50 for each page thereafter.

_____ _____
Signature of Patient or Legal Representative Date

If signed by Legal Representative, relationship to Patient: _____

_____ _____
Signature of Witness Date

(If patient is a minor or unable to sign, complete the following)

_____ _____
Reason Patient Unable to Sign Signature of Parent, Guardian, or State Relationship