



AUTHORIZATION TO ACCESS OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Social Security #: _____ Patient Phone: _____

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

Name of Individual/Facility/Company to Receive PHI

Name of Individual/Facility to Disclose PHI:

NORMAN REGIONAL HEALTH SYSTEM ATTN: HEALTH INFORMATION

Address: _____

Address: 901 NORTH PORTER

City, State: _____

City, State: NORMAN OK 73071

Dates of treatment to be released: _____

- Portion(s) to release: Complete Record, Discharge Summary, History and Physical, etc.

The information will be obtained, used, or disclosed for the following purpose (s) only: Insurance, Continued treatment, Legal, etc.

I understand the cost of providing copies of records are \$1.00 for the first page then \$0.50 for each page subsequent plus actual cost to mail records, and is billed to the requestor in compliance with 76 Okla. Stat § 19.

(Initial above please.) _____

- I am requesting my information to be: delivered to me, faxed, mailed, or completed upon request.

I understand: At the request of the patient or patient's representative... I may revoke this authorization... I release the entities listed above... Information used or disclosed pursuant to this authorization may be subject to redisclosure... I have the right to inspect the Health Information to be released... Unless the purpose of this authorization is to determine payment of a claim for benefits...

I understand the information authorized for release may include records which may indicate a presence of a communicable or non communicable disease.

Signature of Patient or Legal Representative

Date

Description of Legal Representative's Authority

Expiration Date of Authorization

