NORMAN REGIONAL Health System

Norman Regional
Norman Regional Moore
Norman Regional HealthPlex

ROI

AUTHORIZATION TO ACCESS OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name:_____ Date of Birth: _____

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:

_____

Address: _____

City, State: _____

Name of Individual/Facility to Disclose PHI:

_____

Address: _____

City, State: _____

Dates of treatment to be released: _____

Portion(s) to release:

- ☐ Complete Record (Every page)
- ☐ Emergency Department Record
- ☐ Physician Progress Notes
- ☐ EKG/Echo
- ☐ Discharge Summary
- ☐ Operative Report
- ☐ Physicians Orders
- ☐ Other (specify) _____
- ☐ History and Physical
- ☐ Pathology Report
- ☐ Lab/X-ray Reports

The information will be obtained, used, or disclosed for the following purpose (s) only:

☐ Insurance ☐ Continued treatment ☐ Legal ☐ At the request of the patient or patient's representative
☐ Other (specify) _____

I understand that there is a cost associated with providing copies of records as well as postage. Norman Regional Health System may charge the requestor in compliance with 76 Okla. Stat § 19(A)(2). This is the only compensation the disclosing entity may receive for production of records.

_____
(Initial above please.)

I am requesting my information to be:

- ☐ digital format
- ☐ faxed to the above requestor
- ☐ mailed to the above requestor (verification/or copy of photo ID is required)
- ☐ patient walk in / receive records at time of request

I understand:

At the request of the patient or patient's representative

- I may revoke this authorization at any time, in writing except revocation will not apply to information already 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 Practices. Unless revoked or otherwise indicated, the automatic expiration date will be one year from the 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 covered by the authorization. The entity authorized to disclose the information will not be compensated by the recipient for the disclosure, except for the cost of copying and mailing as authorized by law.
- 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 and I understand this release requires my signed 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 or payment for my care on my signing this authorization.

_____ _____
Signature of Patient or Legal Representative Date

_____
Description of Legal Representative's Authority

_____
Expiration Date of Authorization

Patient Label