TULSA WOMEN'S HEALTHCARE

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Social Security #:_____ Date of Birth: _____

Name/Address of Individual/Facility to **Receive** PHI:
Tulsa Women's Health Care
10011 S. Yale Ave., Suite 100
Tulsa, OK 74137
Phone #: (918)299-5151 Fax #: (918)299-2171

Name/Address of Individual/Facility to **Disclose** PHI:
_____
_____
_____
_____

Information authorized to be disclosed or obtained:
____ History & Physical ____ Hospital Records ____ Operative Reports ____ Lab Reports ____ Office Notes
____ X-Ray/Ultrasound Reports ____ All Medical Information
____ Medical Records from (date range) _____ to _____

This information will be disclosed/obtain for the following purpose only:
____ Insurance ____ Continued Treatment ____ Legal ____ At the request of the 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, 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.
- 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.
- **THE INFORMATION AUTHORIZED FOR THE RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE.**

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient Date