AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

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

1. I authorize the use or disclosure of the above named individual's health information as described below:
2. The following individual or organization is authorized to make the disclosure:

_____

Address _____

3. The type and amount of information to be used or disclosed is as follows: from (date) _____ to (date) _____

☐ problem list
☒ medication list
☐ list of allergies
☐ immunization record
☒ most recent history and physical
☒ most recent discharge summary
☒ laboratory results
☒ x-ray and imaging reports
☒ consultation reports
☐ other

☐ psychotherapy notes
☐ treatment plan
☐ letters &/or forms filled out on behalf of patient
☐ psychological, psycho-social, IQ testing & results
☐ laboratory results
☐ case managers notes
☐ physicians notes

_____
_____

4. **THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE, OR RELATE TO MENTAL HEALTH, OR DRUG, SUBSTANCE OR ALCOHOL ABUSE.**

5. This information may be **disclosed to** and **used by** the following individual or organization:

☑ Social Security Law Center
2411 E. Skelly Drive, Ste. 101
Tulsa, OK 74105
918-388-7752
918-388-0171 x208 fax

_____ Social Security Law Center
3400 Tuxedo Blvd. #D
Bartlesville, OK 74006
918-335-3100
918-335-3200 fax

_____ Social Security Law Center
227 N. Main
Miami, OK 74354
918-542-8300
918-542-8302 fax

_____ Social Security Law Center
625 N.W. 13th St
Oklahoma City, OK 73103
405-606-7440
405-606-7441 fax

for the purpose of: Social Security Disability

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand 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. Unless otherwise revoked, this authorization will expire on the following date, event or condition: one year. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that the records requested may be protected under 42 C.F.R., Part 2. Governing Alcohol, Drug Abuse patient records, the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), 45 C.F.R. parts 160 & 164, state laws and regulations regarding the confidentiality of medical records, and cannot be released without my consent unless otherwise provided by applicable law. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact (insert HIM director, privacy officer, or other office or individual's name or contact information).

SIGN HERE

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness