OKLAHOMA STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

PATIENT INSTRUCTIONS

I. INDIVIDUAL INFORMATION (FOR PERSON WHOSE INFORMATION WILL BE SHARED)

Write your name, date of birth, complete address, area code and telephone number in the spaces provided.

II. SCOPE & PURPOSE FOR SHARING INFORMATION

This section explains what protected health information is and lets you know that you are allowing your protected health information to be shared with the person (s) you name in Section II A.

A. Person/Organization Receiving Information and Purpose for Sharing

Write the person/organization's name you wish to share information with, their address, phone number and fax number, their relationship to you (example: lawyer, family member, etc.), and the purpose for which you wish to share the information. **If you write more than one person/organization in this section, the information you check in Section B will be shared with everyone listed.**

B. (1) This section lists what information you want to share. You can check one or more boxes, **unless** you are sharing psychotherapy notes. If you are sharing psychotherapy notes, you can only check that box and no others.

(2) List the dates of service for the information you want to share (if you don't know the exact dates, try to at least give the month and year), or you can choose to share all your records by writing the word "all".

III. EXPIRATION & REVOCATION

A. Expiration

By law, your permission to share information can only last for a certain amount of time. You must check one box.

B. Right to Revoke

You can change your mind about sharing this information at any time. If you change your mind, you must write to the address listed under your signature in Section IV.B and ask that your information no longer be shared. Information may already have been shared before your written request is received.

IV. ACKNOWLEDGEMENTS & SIGNATURES

A. Acknowledgements

1. This section explains that you voluntarily signed the form and that you can't be denied eligibility for benefits, treatment, enrollment, or payment of claims if you don't sign the form.

2. If you check the box and write your initials in this section, you are agreeing to share your protected health information for marketing purposes. The person/company asking you to sign the form may receive some sort of payment for your information.

3. If you give permission to share your protected health information with someone who is not a health plan or health care provider, (family member, etc) privacy regulations may no longer protect the information.

4. You may look at or get a copy of the protected health information shared under this form by writing to the address listed under your signature in Section IV.

B. Signature - Sign and date the form in the spaces provided.

If you are agreeing to share alcohol or drug abuse records, law protects that information in certain instances. If the box under your signature is checked, the person or organization receiving your alcohol or drug abuse records under this authorization may not be able to share this information without your written permission.

The last paragraph under the gray-shaded box is for the physician/provider use only.