Pediatric Specialists OF TULSA

AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

_____

**Patient Name** **DOB**

**I hereby authorize** _____

**Name of person/Organization Disclosing PHI**

**To release the following information to** (Name and address of person/Organization **Receiving** PHI) _____

_____

_____

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**Purpose (check one):** ☐ Specialists ☐ Transfer of Care ☐ Personal ☐ Other_____

**Information to Be Shared, Check one or more below:**

☐ Entire Medical Record (All records except psychotherapy notes) ☐ Immunization record ☐ Billing Records

☐ X-ray/Imaging reports ☐ Lab/Pathology Reports ☐ Mental Health Records (incl: ADD/ADHD) ☐ Most recent encounter

☐ Most recent Well visit ☐ Psychotherapy Notes (If checking this box no other boxes may be checked)

☐ Other: _____

☐ Medical information compiled between _____ and _____ (Insert either date(s) or "all")

**The information may be disclosed for the following purpose(s) only:**

☐ insurance ☐ Continued Treatment ☐ Legal ☐ At my or my representative's request

☐ Other: _____

**I understand that by voluntarily signing this authorization:**

- I authorize the use of disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.
- I understand I cannot restrict information that may have been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following event: _____

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Relation (if other than patient) Exp. Date (If longer than one year from date of signature)