



Oklahoma Surgical Hospital

Authorization to Use or Disclose Health Information

I hereby authorize **Oklahoma Surgical Hospital** to release the following information to:

Name: _____

Address: _____

concerning the diagnosis, treatment, and prognosis of: _____.

Name of Patient

Date of Birth Phone Number

Date of Service

Purpose: 1. Personal Records _____
2. Further Treatment _____
3. Marketing _____ Remuneration _____
4. Other _____

Social Security Number

This authorization will expire on _____ (consent date or event) or 6 months after the date of signature.

I UNDERSTAND THAT MY MEDICAL RECORDS MAY CONTAIN INFORMATION THAT INDICATES THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE. THIS MAY INCLUDE BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOW AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

- The following individual(s) or organization(s) are authorized to make the disclosure: _____
- The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated.)
 Complete record
 Pertinent information which includes: Facesheet, Discharge Summary, History & Physical, Physician Orders, Statement of Diagnostic Test Results
 Lab results
 X-ray and Imaging Reports (Actual films must be checked out from the Imaging Center)
 Consultation reports from (please supply doctors' names): _____
 Operative report
 Other (please describe): _____
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that 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.
- I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
- I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.
- I understand there may be a charge for copies of my records needed for personal use. The cost is \$.50 for each page.
- I understand there may be a charge for copies of my records being sent to an insurance company, attorney's or responding to a subpoena. The cost will be a \$10.00 base fee, \$.50 for each page, and actual postage or delivery charge.

Signature of Patient or Legal Representative
If signed by Legal Representative, relationship to Patient:

Date

Signature of Witness

Date

Reason Patient Unable to Sign

Signature of Parent, Guardian, or State Relationship