Authorization for Disclosure of Protected Health Information

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

I hereby authorize the use or disclosure of the Protected Health Information described to be provided to or obtained by the following:

Name of Individual/Facility/ Company to Receive PHI, (If Michael Robinson's office please select the second box.):

⬜ Different providers office

_____
_____
_____
_____

⬜

Michael Robinson Family Medical Clinic Main
1900 W 2nd St, Suite A.
Elk City, Ok, 73644
P: (580) 303-9060 F: (877) 592-0771

Information authorized for use, disclosure, or to be obtained:

□ All medical information concerning this patient
□ Medical information concerning this patient compiled between _____to_____.
□ Only:_____

Dates of Treatment, if known: _____

The information will be obtained, used, or disclosed for the following purpose(s) only:

□ Insurance □ Continued Treatment □ Legal
□ At the request of the patient or Patient's Representation
□ Other (specify)_____

I understand:

- I may revoke this authorization at any time, in writing, except revocation will not apply to the information already used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation to the Privacy Officer. Unless revoked or otherwise indicated, the automatic expiration date will be one year from the date of signature or upon occurred the following event: _____
  _____
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of protected health information covered by this authorization.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and not 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 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 concern the provision of treatment or payment for my care on my signing this authorization.

I understand that my medical information may indicate that I have a communicable or venereal disease which may include but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus (HIV), also known Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I am or have been treated for psychological or psychiatric conditions or substance abuse.

_____ _____
Signature of Patient or Legal Representative **Date**

_____ _____
Description of Legal Representative's Authority **Witness**

Notice of Rights: Information in your medical record that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances disclosure to persons who have had risk except disclosure pursuant to an order of the court or the Department of Health, disclosure among health care providers or disclosure for statistics epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless the identifying information is authorized by you, by an order of the court, the Department of Health, or by law.