AUTHORIZATION FOR ACCESS BY PATIENT OR 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 below to be provided to or obtained by the following:

Name of Individual/Facility/ to Receive PHI

_____
_____
_____
_____
Fax: _____

Name of Facility to Disclose PHI

Utica Women's Specialists, LLC
1725 E. 19th Street, Suite 401
Tulsa, OK 74104
Phone: 918-749-1413 Fax: 918-749-0234

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

- □ All medical information concerning this patient
- □ Billing information dated _____
- □ Medical information of 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 representative
□ Other (specify)_____

I understand:

- If the record(s) are released into my own keeping, I will pay $.50 cents per page before such records are released and I will pay the actual cost of postage if the record is to be mailed. Charges for records are in accordance with 76 O.S. § 19(A)(2).
- I authorize the use or 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 at any time. I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- I have a right to receive a copy of this authorization. I have the right to inspect the health information to be released and I may refuse to sign 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.
- This authorization will expire automatically one year from the date it is signed unless revoked sooner in writing to the person/organization disclosing the information.

I understand that my medical information authorized for use or disclosure may include information that may indicate the presence of a communicable or non-communicable disease and may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have 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 Expiration Date of Authorization

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 including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court of the Department of Health, disclosure among health care providers or disclosure for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court or the Department of Health or by law.