MEDICAL AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

As required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164

Patient Name:_____

D.O.B:_____ **Social Security #**:_____

I hereby authorize: **ADVANCED PAIN SPECIALISTS OF TULSA**

Name of Person/Organization Disclosing PHI

to release the following information to **Name and Address of Person/Organization Receiving PHI:**

***Name, Address, Phone and Fax**	***Relationship**	***Purpose**

Information to be shared:
□ Entire Medical Record
□ Psychotherapy Notes (if checking this box, no other boxes may be checked)
□ Billing Information for_____
□Mental Health Records
□ Substance Abuse Records
□ Medical information compiled between_____ and _____
□ Other:_____

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 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. 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 already 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.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient Expiration date (if longer than one year from the date of signature or no event is indicated)

Office Use Only – Received by: