The Physicians Group

OSSO

OKLAHOMA SPORTS SCIENCE & ORTHOPAEDICS

PATIENT AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date: _____

Address: _____ Phone: _____

Social Security # _____ DOB: _____

Please Release My Medical Records To: Fax: _____

Name: _____ Phone: _____

Address: _____ Contact Person: _____

for the following purposes: _____

_____

By checking the spaces below, I specifically authorize the use or disclosure of the following information and/or medical records, if such information and/or records exist:

- ☐ Please send the entire medical record (all information)
- ☐ Clinic Office Notes
- ☐ Laboratory Reports
- ☐ Radiology Reports
- ☐ Hospital Records
- ☐ Physical Therapy
- ☐ Billing Statements
- ☐ Other: _____

I understand that, if a person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. Therefore I release The Physicians Group from all liability arising from this disclosure of my health information.

I further understand that the person I am authorizing to use or disclose the information may receive compensation for doing so. I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization.

Finally, I understand that I may revoke this authorization at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire 6 months from the date of signing or until (date) _____

By Oklahoma law, The Physicians Group is required to notify you that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome.

_____ _____

Print Patient Name or Name of Legal Representative | Relationship to Patient

_____ _____

Signature of Patient or Patient's Legal Representative | Date

_____ _____

Signature of Witness | Date

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