NORMAN REGIONAL
Health System

ROI

AUTHORIZATION TO ACCESS OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: ___________________________________ Date of Birth: ____________________________

Social Security #:________________________________ Patient Phone: ____________________________

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

Name of Individual/Facility/Company to Receive PHI:

____

Address: _____________________________________

City, State: ___________________________________

Phone #: _____________________________________

Fax #: _______________________________________

Name of Individual/Facility to Disclose PHI:

____

Address: _____________________________________

City, State: ___________________________________

Phone #: _____________________________________

Fax #: _______________________________________

Dates of treatment to be released: ____

Portion(s) to release:
- ❒ Complete Record (Every page)
- ❒ Emergency Department Record
- ❒ Physician Progress Notes
- ❒ EKG/Echo
- ❒ Discharge Summary
- ❒ Operative Report
- ❒ Physicians Orders
- ❒ Other (specify) ________________________
- ❒ History and Physical
- ❒ Pathology Report
- ❒ Lab/X−ray Reports

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 that there is a cost associated with providing copies of records as well as postage. Norman Regional Health System may charge the requestor in compliance with 76 Okla. Stat § 19(A)(2). This is the only compensation the disclosing entity may receive for production of records.

____
(Initial above please.)

I am requesting my information to be:
- ❒ delivered to me or my legal representative by calling when records are available at #: ________________________________
- ❒ faxed to the above requestor
- ❒ mailed to the above requestor (verification/or copy of photo ID is required)
- ❒ completed upon request

I understand:
At the request of the patient or patient's representative
- I may revoke this authorization at any time, in writing except revocation will not apply to information already used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Practices. Unless revoked or otherwise indicated, the automatic expiration date will be one year from the date of signature or upon occurrence of the following event: ____
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information covered by the authorization. The entity authorized to disclose the information will not be compensated by the recipient for the disclosure, except for the cost of copying and mailing as authorized by law.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure 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 the right to inspect the Health Information to be released and I understand this release requires my signed authorization.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment or payment for my care on my signing this authorization.

____ ________________________________
Signature of Patient or Legal Representative Date

____
Description of Legal Representative's Authority

____
Expiration Date of Authorization

Patient Label

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