

**AUTHORIZATION FOR ACCESS AND 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 Business/Non-Profit to Receive PHI: Name of Facility/Company to Disclose PHI:

Eastern Oklahoma Donated Dental Services _____
3741 S. Peoria _____
Tulsa, Okla. 74105-3264 _____
(918) 742-5544 Fax: (918) 742-5545 _____

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

_____ All medical information concerning this patient compiled between _____ to _____
_____ All medical records, progress notes, operative reports, x-ray and diagnostic test reports compiled
between _____ to _____.
_____ Only _____.

This information will be obtained, used or disclosed for **Legal and Insurance Purposes:**

I understand:

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. I release the entities above, their agents and employees from any liability in connection with the use of disclosure of the protected health information covered by this 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 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 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 condition the providing 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, hepatitis, syphilis, gonorrhea or the human immunodeficiency virus, also know 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:
Expiration Date: One year

Description of Legal Representative's Authority

Notice of Rights: Information in your medical record that you have or may have a communicable or venereal disease is made confidential 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 or 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 of the Department of Health or by law.