Pain Management of Tulsa

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Office Use Only

Completed: _____
Initial: _____

AUTHORIZATION TO PERMIT DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____Date of Birth: _____Medical Record #_____

Social Security Number: _____Telephone Number: _____

I hereby authorize Pain Management of Tulsa the use or disclosure of the Protected Health Information described below to be provided to or obtained by the following: ☐ Self ☐ Other: _____

Method of pick-up (please choose one): ☐ PMT Office ☐ Mail ☐ Fax: _____

If you choose to have Pain Management mail your medical records, please list the mailing address below:

_____

Street *City* *State* *Zip code*

RECORDS TO BE RELEASED		REASON FOR REQUEST	
____Entire Medical Record	_____Discharge Summary	_____Personal Records	_____Legal (Attorney)
____History & Physical	_____Operative Report	_____Insurance	_____Medical Follow up
____Consultations		_____Other (Specify): _____	
____Dates From: _____ To:_____			
____Other (Specify): _____			

I understand the following:

- I may revoke this authorization at any time by providing a written statement of revocation to PMT. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Practices. I am aware that my revocation will not be effective until received by Pain Management of Tulsa and will not be effective regarding the uses and/or disclosures of my health information that PMT has made prior to the receipt of my revocation. Unless revoked or otherwise indicated, the automatic expiration date will be one year from the date of signature or upon occurrence of the following events(s): _____
- I release the entities listed above, their agents and employees from any liability in connections with the use or 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 of this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal laws. 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 release and I am under no obligation to sign this authorization. I am entitles to a copy of this form. A copy of this form shall be valid as the original.
- 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

I understand that my medical information may indicate that I have a communicable or non-communicable disease which may include, but is not limited to, disease such as hepatitis, syphilis, gonorrhea, human immunodeficiency virus also known as acquired immune deficiency syndrome (AIDS). I further understand that my medical information may indicate that I have or may have been treated for psychological or psychiatric conditions or substance abuse.

_____

Signature of Patient or Legal Representative Date

_____

Description of Legal Representative's Authority Date

_____

Signature of Witness Date

NOTICE OF RIGHTS: Information in your medical records that you have or may have a communicable or non-communicable disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to person 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, and order of the Court of the Department of Health by law.