McCurtain Memorial Hospital Since 1953

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT NAME:

LAST **FIRST** **MIDDLE**

DOB: ______________________ **SSN:** ______________________

COMPLETE THE FOLLOWING BY INDICATING ITEMS THAT YOU WANT DISCLOSED. THE SIGNATURE OF A MINOR PATIENT IS REQUIRED FOR THE RELEASE OF SOME OF THESE ITEMS. IF ALL HEALTH INFORMATION IS TO BE RELASED, THEN CHECK ONLY THE FIRST BOX.

REASON FOR DISCLOSURE:

- ☐ Treatment/Continuing Care
- ☐ Personal use
- ☐ Billing or claims
- ☐ Insurance
- ☐ Legal purposes
- ☐ Disability determination
- ☐ School
- ☐ Employment
- ☐ Other

☐ All Records and Information	☐ Designated Record Set	☐ History/Physical Exam	☐ Past/Present Medications
☐ Emergency Room Records	☐ Operations Reports	☐ Consultation Reports	☐ Discharge Summary
☐ Pathology Lab Test Results	☐ EKG Cardiology Reports	☐ Radiology Reports & Images	Other

*Designated record set includes: history and physical, discharge summary, progress notes, lab, x*rays, and emergency room visit.

FORMAT REQUESTED ☐ Paper:(Deafult) ☐ Electronic:

Dates Requested: ____

This authorization will expire on ________________ or 6 months after the date of signature, I understand this authorization is subject to revocation by me at any time except to the extent that action has already been taken in reliance on it. However, your revocation will not prohibit us from (a) any disclosures we have made or acts we have already taken in reliance on the authorization, or (b) any right associated with an insurer's contest of a claim under its policy, if the authorization was obtained in order to obtain insurance coverage.

To revoke your authorization, send a written request to: ***HIM Department, /1301, Lincoln Rd, Idabel, OK 74745.***

1. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization (45 CFR § 164.508 (c)(2)(i). I also understand that it is hereby my responsibility to notify McCurtain Memorial Hospital, either in person or by notarized letter that I wish to withdraw my consent. The documentation of this formalized communication shall be kept in accordance with state and federal guidelines.
2. I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes (45 CFR § 164.508 (c)(2)(ii).
3. I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) (45 CFR §164.508 (c)(2)(iii).

I authorize McCurtain Memorial Hospital to release the protected health information specified above to:

Signature: Date:

Witness of Notary Signature: ______________________

Authority to sign if not patient: ______________________

Witness of Signature: ______________________

Second witness: ______________________

Notary:

State of: Oklahoma Seal/Stamp:

County of: McCurtain County

On this day of ________, 20__, I certify that the (preceding) (following) (attached) document is a true, exact, complete and unaltered copy made by me of the document presented to me by ______________________.