Pulmonary and Sleep Center of Oklahoma

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____
DATE OF BIRTH: _____
I hereby authorize the use or disclosure of the Protected Health Information described below to be provided to or obtained by the following:

Name and Address of Individual/Facility/Company to Receive PHI	Name and Address Individual to Disclose PHI
_____	_____
_____	_____
_____	_____

Information authorized for use or disclosure to be obtained:
__ TB skin test results __Lab reports __XRAY reports __Progress notes __History and Physical
__Discharge summaries __Operative report __Pulmonary Function Testing __Pathology report
__Radiology studies: _____
Dates:_____

The information will be obtained, used, or disclosed for the following purposes only:
__Insurance __Continued treatment __Legal __At the request of the patient or patient's representative
__Other: _____

I understand:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already retained, 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 Rights.
- 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. The entity authorized to disclose the information will not be compensated by the recipient for such disclosure. Normal applicable fees, such as copy fees, may apply.
- Information used or disclosed pursuant to this authorization may be subject to redisclouse 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.
- 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, payment, enrollment in a health plan, or eligibility for benefits on obtaining this authorization.

I understand that the information authorized for use or disclosure may include information which may indicate the presence of a communicable disease and may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and human immunodeficiency viruses also known 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:_____ Date: _____
Signature of Personal Representative:_____ Date: _____
Representative authority to act for the patient:_____