ADVANCED PAIN MANAGEMENT CENTER OF OKLAHOMA, LLC

MEDICAL AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

As required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164

Patient Name:____

D.O.B:_________________________________ **Social Security #**:_______________________________________

I hereby authorize:____

Name of Person/Organization Disclosing PHI

to release the following information to **Name and Address of Person/Organization Receiving PHI:**

*Name, Address, Phone and Fax	*Relationship	*Purpose
Advanced Pain Management Center of Oklahoma, LLC		Treatment
3840 S 103rd East Ave, Suite 100, Tulsa, OK 74146		
918-921-9700ph 918-292-8263 fax		

Information to be shared:

□ Entire Medical Record
□ Psychotherapy Notes (if checking this box, no other boxes may be checked)
□ Billing Information for__________________________________
□Mental Health Records
□ Substance Abuse Records
□ Medical information compiled between___________ and ___________
□ Other:____

The information may be disclosed for the following purpose(s) only:

□ Insurance □ Continued Treatment □ Legal □ at my or my representative's request
□ Other: ____

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.

____
Signature of Patient or Legal Representative

____
Date

____
Relationship to Patient

____
Expiration date (if longer than one year from the date of signature or no event is indicated)

Office Use Only – Received by: