

GI of Norman, LLC, 1125 N. Porter, Ste. 301 Norman OK, 73071

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

I. INDIVIDUAL INFORMATION (FOR PERSON WHOS INFORMATION WILL BE SHARED)

Name	Date of Birth	
Address	City	
()		
Telephone Number	State	Zip

II. SCOPE AND PURPOSE FOR SHARING INFORMATION

I understand that protected health information is health that identifies me. The purpose of this authorization is to allow GI of Norman LLC to share my protected health information.

III. AUTHORIZATION AND INFORMATION TO BE SHARED

I authorize GI of Norman LLC as set forth below, to share my protected health information for reasons *in addition to those already permitted by law (which includes spouse, personnel involved in the treatment and continuum of my care, medical operations and payment for services).*

A. Persons/Organizations Authorized to Receive my Information:

(Name, Address, Phone, and Fax)	Relationship	Purpose

B. Information shared:

1. Check one or more boxes below:

- | | | |
|--|---|---|
| <input type="checkbox"/> Entire Medical Record (includes all records except Psychotherapy Notes) | <input type="checkbox"/> Laboratory Report(s) | <input type="checkbox"/> Operation Report(s) |
| <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Radiology Films | <input type="checkbox"/> Alcohol/Drug use Records |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Radiology Report(s) | <input type="checkbox"/> EKG Report(s) |
| <input type="checkbox"/> Physician's Orders | <input type="checkbox"/> Operation Report(s) | <input type="checkbox"/> Physician's Orders |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Other |
| <input type="checkbox"/> Consultation Report(s) | | |

2. Conveying Services Between _____ and _____ (Insert either date(s) or "ALL")

IV. EXPIRATION AND REVOCATION:

A. This Authorization Will Expire (must choose one):

- 3 years after last office encounter Other (Insert date(s) or "event"): _____

B. Right to Revoke

I understand that I may change this authorization at anytime by writing to the addresses listed at the top of this form. I understand I cannot restrict information that may have already been shared based on this authorization.

v. ACKNOWLEDGEMENTS AND SIGNATURES

A. Acknowledgements

- I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment claims.
- If checked and initialed, GI of Norman is authorized to share my protected health information for the purpose of marketing. I understand GI of Norman may receive either direct or indirect compensation for sharing my information _____.
- I understand I may inspect or obtain a copy of the health information shared under this authorization by sending a written request to the address listed at the top of the form.
- I understand GI of Norman LLC, as a member of the Oklahoma Physician Health Exchange (OPHX) may utilize an electronic network to exchange my protected health information with other providers unless I choose not to participate.
- I acknowledge information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

B. Signature This document must be signed by the individual or the individual's legal representative.

- Signature (Patient or Legal Representative) Date

Printed Patient or Legal Representative Name	Capacity of Legal Representative (if applicable)
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**OKLAHOMA STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)
PATIENT INSTRUCTIONS**

I. INDIVIDUAL INFORMATION (FOR PERSON WHOSE INFORMATION WILL BE SHARED)

Write your name, date of birth, complete address, area code and telephone number in the spaces provided.

II. SCOPE & PURPOSE FOR SHARING INFORMATION

This section explains what protected health information is and lets you know that you are allowing your protected health information to be shared with the person (s) you name in Section III A.

III. AUTHORIZATION & INFORMATION TO BE SHARED

In most cases, your protected health information can be shared for treatment, payment, and healthcare activities under the Health Insurance Portability Authorization Act (HIPAA). For reasons in addition to permitted treatment, payment, and healthcare activities, you must complete Sections III A & B as follows:

A. Person/Organization Receiving Information and Purpose for Sharing

Write the person/organization's name you wish to share information with, their address, phone number and fax number, their relationship to you (example: lawyer, family member, etc.), and the purpose for which you wish to share the information. **If you write more than one person/organization in this section, the information you check in Section B will be shared with everyone listed.**

B. (1) This section lists what information you want to share. You can check one or more boxes, **unless** you are sharing psychotherapy notes. If you are sharing psychotherapy notes, you can only check that box and no others.

(2) List the dates of service for the information you want to share (if you don't know the exact dates, try to at least give the month and year), or you can choose to share all your records by writing the word "all".

IV. EXPIRATION & REVOCATION

A. Expiration

By law, your permission to share information can only last for a certain amount of time. You must check one box.

B. Right to Revoke

You can change your mind about sharing this information at any time. If you change your mind, you must write to the address listed at the bottom of this form and ask that your information no longer be shared. Information may already have been shared before your written request is received.

V. ACKNOWLEDGEMENTS & SIGNATURES

A. Acknowledgements

1. This section explains that you voluntarily signed the form and that you can't be denied eligibility for benefits, treatment, enrollment, or payment of claims if you don't sign the form.

2. If you check the box and write your initials in this section, you are agreeing to share your protected health information for marketing purposes. The person/company asking you to sign the form may receive some sort of payment for your information.

3. If you give permission to share your protected health information with someone who is not a health plan or health care provider, (family member, etc) privacy regulations may no longer protect the information.

4. You may look at or get a copy of the protected health information shared under this form by writing to the address listed at the bottom of the form.

5. The information shared may include records which may indicate the presence of a communicable or noncommunicable disease.

B. Signature - Sign and date the form in the spaces provided.

If you are agreeing to share alcohol or drug abuse records, law protects that information in certain instances. If the box under your signature is checked, the person or organization receiving your alcohol or drug abuse records under this authorization may not be able to share this information without your written permission.