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

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

Name ______________________ Date of Birth ______________________

Address ______________________ City ______________________

Area Code & Telephone Number ______________________ State __________ Zip __________

## II. SCOPE & PURPOSE FOR SHARING INFORMATION

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

## III. AUTHORIZATION & 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.

A. Persons/Organizations Authorized to Receive My Information:

| (Name, Address, Phone & Fax) | Relationship | Purpose (i.e “billing only” or “any”) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

B. Information to be shared

**1.** Check one or more boxes below.

- ☐ Entire Medical Record (includes all records except Psychotherapy Notes)
- ☐ Psychotherapy Notes
- ☐ Mental Health Records

| | | |
|---|---|---|
| ☐ Pathology Report | ☐ History and Physical | ☐ Operation Report(s) |
| ☐ Progress Notes | ☐ Consultation Report(s) | ☐ Discharge Summary |
| ☐ EKG Report(s) | ☐ Laboratory Report(s) | ☐ Radiology Report(s) |
| ☐ Physician’s Orders | ☐ Radiology Films | ☐ Alcohol or Drug Abuse Records |
| ☐ Other | | |

**2.** Covering Services Between _____________ and _____________ (Insert either date(s) or “all.”)

## IV. EXPIRATION & REVOCATION

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

☐ 1 year from signature date ☐ Other (insert date if **less** than 1 year or list event): ______________________

B. Right to Revoke

I understand I may change this authorization at any time by writing to the address listed at the bottom of this form. I understand I cannot restrict information that may have already been shared based on this authorization.

## V. ACKNOWLEDGEMENTS & SIGNATURES

### A. Acknowledgements

**1.** I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.

**2.** I understand if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information.

**3.** I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request to the address listed at the bottom of the form.

4. I understand GI of Norman, LLC as a member of 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.

**5. 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.

X ______________________________________________

Printed Patient or Legal Representative Name | Capacity of Legal Representative (if applicable)

X ______________________________________________

Signature (Patient or Legal Representative) | Date

**Physician / Clinic Address**: GI OF NORMAN, LLC 1125 N PORTER STE 301 NORMAN, OK 73071