Plaza Medical Group, PC

CONSENT TO RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: ______________________ Social Security No.: ______________

Date of Birth: ______________________ Medical Record No.: ______________

I understand that Plaza Medical Group is requesting that I authorize it to use or disclose my Protected Health Information as described below.

☐ **I am authorizing Plaza Medical Group to <u>disclose</u> my Protected Health Information to:**

Name of Individual/Organization and Relationship: **Address and Phone Number:**

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Information authorized for use or disclosure:

☐ All medical information concerning this patient from Plaza Medical Group.
☐ All medical information concerning this patient from ______________________ (clinic / physician).
☐ Only: ______________________
Dates of Treatment, if known: ______________________

The information will be used or disclosed for the following purpose(s) only:

☐ At the request of the patient or patient's representative
☐ Other (specify) ______________________

I understand:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already 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 Practices. Unless revoked or otherwise indicated, the automatic expiration date will be 5 years from the date of signature or upon occurrence of the following event: ______________________
- 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 covered by this authorization.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law.
- I have the right to inspect the health information to be released and I may refuse to sign this authorization.
- I understand that Plaza Medical Group will not condition the provision of treatment for my care on my signing this authorization.

I understand that my medical information may indicate that I have a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea or the human immunodeficiency virus, 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 or Legal Representative Date

____
Description of Legal Representative's Authority

____
Health Care Provider, if Psychotherapy Notes will be accessed or disclosed

REVOCATION OF AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: ______________________________ Social Security No.: ______________________

Date of Birth: ______________________________ Medical Record No.: ______________________

I hereby revoke the authorization given on _________________ to Plaza Medical Group related to the following:

(describe purpose of authorization): ____

If the revocation is limited (for example, you want us to stop disclosing some but not all of the Information described), please describe the limitation here. If you leave this part blank, we will treat the revocation as complete.

Limitations:____

Signature: ____ Date: ____________________________

If you are signing as the patient's representative:

Print Your Name: _____________________________________

Describe Your Authority:________________________________

Your revocation will be effective once it is received and processed at the following address:

Privacy Officer
Plaza Medical Group
3433 NW 56th Street, Suite 400
Oklahoma City, OK 73112