McBRIDE ORTHOPEDIC HOSPITAL

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Full legal name		
Other names used	**Date of birth**	**SSN (last 4 digits only)**
Address		
Home phone ( )	**Work phone** ( )	**Cell phone** ( )

The extent or nature of the information to be released: ***Dates of service:*** _____ ***to*** _____.

☐ Face Sheet
☐ History and Physical
☐ Operative Report
☐ Pathology Report
☐ Physician Orders
☐ Progress Notes
☐ Discharge Summary
☐ Nurses Notes
☐ Consultations
☐ Emergency Room Record
☐ Lab Reports
☐ EKG
☐ X-Ray Reports
☐ X-Ray CD
☐ MRI Report
☐ MRI CD
☐ CT Scan Report
☐ CT Scan CD
☐ Films
☐ X-Ray Paper Copies
☐ Other Please specify:_____
☐ Entire Chart - Hospital
☐ Entire Chart - Physicians Office

Locations: ☐ Hospital ☐ Clinic

McBride Orthopedic Hospital is hereby authorized to make disclosures to: ☐ **Patient** ☐ **Other individual** ☐ **Organization**
No purpose is required when disclosure is being made to the patient. **Purpose of release:** ☐ Legal ☐ Other:_____

Recipient of records:

Name	
Address	
City, State	**Phone**

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire one year from the date of signing below.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR §164.524, Health Insurance Portability and Accountability Act (HIPAA). I understand that if the person or entity authorized to receive the information is not a healthcare provider or health plan, the released information may no longer be protected by federal privacy regulations. If I have questions about the disclosure of my protected health information, I am aware that I should contact the Health Information Management Department.

By signing below, I specifically authorize McBride Orthopedic Hospital to release my protected health information. The charge is $0.50 for each paper page or $0.30 per digital page.

The information authorized for release may include records that may indicate the presence of a communicable disease or non-communicable disease. 63 O.S. §1-502.2(B). (I 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 Patient's Representative **Date**

If signed by Patient's Representative, state representative's legal authority. ☐ **Parent of Minor** ☐ **Power of Attorney** ☐ **Legal Guardian** ☐ **Other:** _____

The information authorized for release may include drug and/or alcohol abuse treatment records. This category of medical information/records is protected by specific federal confidentiality rules. 42 CFR §164.508. The federal rules prohibit anyone receiving this information or record from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or is otherwise permitted. 42 CFR §164.508. A general authorization for the release of medical or other information is not sufficient for this purpose.

I specifically authorize the release of information related to:
☐ Substance Abuse (including alcohol/drug abuse)
☐ Mental Health (excluding psychotherapy notes which require a separate authorization)
☐ HIV-related information (AIDS-related testing)

_____
Signature of Patient or Legal Representative **Date**