HPI COMMUNITY HOSPITAL
INTEGRIS Network

HPI NORTHWEST SURGICAL HOSPITAL
INTEGRIS Network

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Provider:

Community Hospital South
3100 S.W. 89th Street
Oklahoma City, OK 73159
(405) 602-8100

Community Hospital North
9800 Broadway Extension
Oklahoma City, OK 73114
(405) 419-2980

Northwest Surgical Hospital
9204 N. May Avenue
Oklahoma City, OK 73120
(405) 848-4419

CH Outpatient Therapy Quail
14024 Quail Pointe Drive
Oklahoma City, OK 73134
(405) 340-2025

CH Outpatient Therapy Hand &
CH Outpatient Therapy South
10001 S. Western Avenue
Oklahoma City, OK 73139
Hand: (405) 427-3752
South: (405) 691-5434

Patient Name: _____ **Date of Birth:** _____

Recipient & Purpose of Request:
I authorize Provider to disclose my protected health information to the following ("Recipient"):_____
at this address _____
for this purpose:_____

I authorize Provider to use or disclose the following protected health information of the Patient described above to Recipient described above in a manner consistent with this authorization (check all that apply):

☐ Entire medical record concerning this patient (excluding psychotherapy notes, if any)

☐ Entire billing record concerning this patient

☐ Medical record concerning this patient for the following date(s) of service:_____

☐ Discharge Summary ☐ Operative Report ☐ Labs ☐ X-Ray Report

☐ Billing record concerning this patient for the following date(s) of service:_____

☐ Other:_____

I understand the following:

- Protected health information is health information that identifies me. The purpose of this authorization is to allow Provider to share my protected health information as set forth above.
- I understand that this authorization is voluntary and that I have the right to refuse to sign this authorization. If I refuse, my protected health information will not be used or disclosed by Provider except as otherwise permitted by law. Provider may not condition treatment on my providing this authorization for use or disclosure of my medical information. If I refuse to sign this authorization, I will still be eligible to receive medical services from Provider.
- Subject to certain exceptions, I have the right to revoke this authorization at any time by sending a letter to Provider which gives my name, the date I signed this authorization, and states that I revoke the authorization to use my protected health information. The letter will not affect any actions taken in reliance of my previous authorization.
- This authorization may result in Provider disclosing my medical information to a recipient who could possibly later use or disclose the information without my authorization. Provider cannot control re-disclosure by Recipient.
- I may inspect or copy the information that will be disclosed or used for the purposes set forth in this authorization. I will receive a signed copy of this authorization form and may contact Provider to get a copy if I do not have one.
- **Protected health information authorized for release may include records that indicate the presence of or regarding treatment of HIV/AIDS, sexually transmitted disease, and drug and/or alcohol abuse.**

_____ _____
Signature of Patient or Patient's Representative Date/Time

_____
Printed Name of Patient or Patient's Representative

Description of Representative's authority (attach documentation):
□ Parent of a minor □ Legal guardian
□ Power of attorney
□ Other: _____

This authorization is only effective if it is signed and dated. Unless I revoke this authorization prior to expiration, this authorization expires on _____ (or if this is left blank, one year after the date it is signed).