



AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

I hereby authorize Okmulgee Memorial Hospital to release the following information contained in its hospital records to:

Name: _____

Address: _____

Concerning the diagnosis, treatment, and prognosis of: _____

Name of Patient	Date of Birth
Date of Service	Purpose: 1. Personal Records _____ 2. Further Treatment _____
	3. Marketing _____ Remuneration: _____
	4. Other: _____

This authorization will expire on _____ (consent date or event) or 6 months after date of signature.

I understand that the information authorized for release may include records which may indicate the presence of a communicable or noncommunicable disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and 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.

1. The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated.)
 - Complete record
 - Pertinent information which includes: Face sheet, Discharge Summary, History & Physical, Physician Orders, Statement of Diagnostic Test Results
 - Lab Results
 - X-ray and Imaging Reports (Actual films must be checks out from the Imaging/Radiology Department)
 - Consultation reports from (please supply doctors' names): _____
 - _____
 - Operative Reports
 - Other (please describe): _____
2. 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 that 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.
3. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
4. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

Signature of Patient or Legal Representative
If signed by Legal Representative, relationship to patient:

Date

Signature of Witness
(If patient is a minor or unable to sign, complete the following)

Date

Reason Unable to Sign

Signature of Parent, Guardian,
or State Relationship