Stillwater FamilyCare
1921 West 6th Ste A Stillwater, OK 74074
(405) 533-2433 Fax: (405) 533-2434

HIPAA Release of Information

AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that by signing this release I am not authorizing the parties in receipt of this information to further disclose the information unless another authorization is obtained from me, or unless such disclosure is specifically required or permitted by law. However, I understand that this information may be subject to re-disclosure by the recipient, and that it will no longer be protected by the clinic, hospital, or individual that released it originally.

Patient name:_____________________________________ **ID Number:**_______________________________________

Persons/organizations providing the information:
____
____
____

Persons/organizations receiving the information:
____
____
____

Specific description of information (including date(s)):____
____
____
____

Section B: Must be completed only if a health plan or health care provider has requested the authorization

The patient or the patient's representative must read and initial the following statements:

a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form.
Initials: ________

b. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.
Initials: ________

Section C: Must be completed for all authorizations

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on ____/____/________ (MM/DD/YR) Initials: ________

2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any affect on any actions that they took before they received the revocation.
Initials: ________

3. I understand that my medical information may indicate that I have a communicable disease or non communicable disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus (HIV). I further understand that my medical information may indicate that I have or have been treated for psychological conditions or substance abuse.
Initials: ________

____ _________________________
Signature of patient or patient's representative **Date**
(Form MUST be completed before signing)

Printed name of patient's representative:____

Relationship to patient:____