OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I. PATIENT INFORMATION (For Patient Whose Information Will Be Obtained or Released) – Please Print

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Area code & phone number: _____ Date: _____

If you want your medical information released to family members or friends, please list names and relationships here:

_____ _____
Name/Relationship Name/Relationship

_____ _____
Name/Relationship Name/Relationship

I AUTHORIZE Oklahoma Cancer Specialists and Research Institute TO (check one): ☐ Obtain Information from: ☐ Release Information to:

_____ _____
Name of person(s), provider, or facility Relationship

_____ _____
Address, City, State, Zip Code Area code, phone number

Purpose of Request (please check appropriate box): ☐ Healthcare ☐ Insurance Coverage ☐ Legal ☐ Personal ☐ Other

Information to be Obtained or Released (please check all that apply): ☐ Medical Records ☐ Billing Records ☐ Other

If other, please specify: _____

A. Covering services between _____ and _____ (insert dates or "all.")

B. This authorization will expire (must choose one): ☐ 12 months from the date signed, OR ☐ Other

II. ACKNOWLEDGEMENTS AND SIGNATURES

A. I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.

B. I understand if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information.

C. I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request to Oklahoma Cancer Specialists and Research Institute.

D. I acknowledge information authorized for release may include records, which may indicate the presence of a communicable or non-communicable disease.

E. Right to Revoke – I understand I may change this authorization at any time by writing to Oklahoma Cancer Specialists and Research Institute. I understand I cannot restrict information that may have already been shared based on this authorization.

F. This document must be signed by the patient or the patient's legal representative.

Patient or legal representative

Signature: _____ Date: _____

Printed Name: _____ Relationship to patient: _____
(if applicable)