

☐ Cedar Ridge: 6501 NE 50<sup>th</sup> St, Oklahoma City, OK 73141 p(405)605-5944 f(405) 424-0267

Description of Legal Representative's authority if not signed by patient

☐ Bethany Behavioral Health: 7600 NW 23<sup>rd</sup> St, Bethany, OK 73008 p(405)792-5352 f(405)792-5375

## AUTHORIZATION FOR USE & DISCLOSURE (RELEASE OR REQUEST) OF PROTECTED HEALTH INFORMATION

This form will authorize Cedar Ridge Hospital to use and disclose or request certain health information about the person named below. All items must be completed and the authorization signed to be valid. I understand this authorization is voluntary; I may refuse to sign this authorization and I understand that Cedar Ridge Hospital may not withhold treatment because I refuse to sign this authorization.

| F   | P <mark>atient's Name</mark> :   |  |  | Date of Birth:   |  |
|---|--|--|--|--|--|
|   | The information specified below may be released to or requested from:  |  |  |  |  |
| 1   | Name/Agency:   |  |  | Telephone:   |  |
| F   | Address:   |  |  | <mark>Fax:</mark>  |  |
| C   | Address: State:  |  |  | <mark>Zip:</mark>  |  |
| -   | The specific purpose(s) for this discinum my personal records; shate other (please describe)   | aring with other healthcare p  | orovid   | ers as needed;   | d, (2) List the dates of   |
| t   | reatment.  |  |  |  |  |
|   | ✓ INFORMATION  | DATES OF SERVICE   | <b>✓</b>   | INFORMATION  | DATES OF SERVICE   |
|   | Psychiatric Evaluation   |  |  | Physician's Orders   |  |
|   | Psychosocial History   |  |  | Education Records  |  |
|   | Psychological Testing  |  |  | Treatment Plans  |  |
|   | History and Physical   |  |  | Progress Notes   |  |
|   | Current Medications  |  |  | Verbal Exchange of Information   |  |
|   | Laboratory Report  |  |  | Verbal Communication   |  |
|   | Discharge Summary  |  |  | Other:   |  |
|   |  |  | +  |  |  |
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