CEDAR RIDGE

☐ Cedar Ridge:
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p(405)605-5944 f(405) 424-0267

☐ Bethany Behavioral Health:
7600 NW 23rd 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.

1. I authorize Cedar Ridge Hospital to disclose or request health information, as described below, from the medical record of:
   Patient's Name: _____ Date of Birth: _____

2. The information specified below may be released to or requested from:
   Name/Agency: _____ Telephone: _____
   Address: _____ Fax: _____
   City: _____ State: _____ Zip: _____

3. The specific purpose(s) for this disclosure is/are (check ✓ your selection):
   ____ my personal records; ____ sharing with other healthcare providers as needed;
   ____ other (please describe)_____

4. SPECIFY EXACT INFORMATION TO BE RELEASED: (1) Place a check (✓) next to the specific information needed, (2) List the dates of treatment.

✓	INFORMATION	DATES OF SERVICE	✓	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:	
	Consultation Reports			Other:	

The information I authorize for release may include records which may indicate the presence of a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS) and or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

I acknowledge the following statements:

- This Release of Information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individual Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under.
- Once the requested Protected Health Information (PHI) is disclosed, the PHI's recipient may re-disclose it, therefore Privacy Regulations may no longer protect it.
- I understand that I may revoke this authorization at any time by notifying Cedar Ridge Hospital in writing at ATT: Cedar Ridge Hospital Health Information, of my intent to revoke this authorization, except that if I do notify Cedar Ridge Hospital in writing of my intent to revoke this authorization, such revocation will not have any effect on any actions by Cedar Ridge Hospital taken before the revocation.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- Unless otherwise revoked, I understand this authorization will expire 180 DAYS from the date this form is signed.
- I understand that once the above information is disclosed, the recipient may re-disclose; therefore the federal policy laws or regulations may not protect you and your health information.
- I understand I will be charged for any copies of my medical record or my child's medical record that I request. I understand fees for copies are due and payable before copies are released.
- I understand that I may be asked to show proof that I have the authority to sign an authorization to review and/or receive copies of the above named patient's medical record which I am requesting.
- I agree that a facsimile or photocopy of this authorization is as valid as the original.

_____ _____
Parent/Guardian Signature / Patient's Signature (if 18 or older) Date/ Time

_____ _____
Description of Legal Representative's authority if not signed by patient Date/Time