Parkside
Psychiatric Hospital & Clinic

Authorization for Use and Disclosure of Protected Health Information

For exchange of information between Parkside and ONE facility or person

Patient Label

Patient Name:	Record #:
Address:	Birth Date:
Phone no:	Social Security No:

Name: **Parkside Hospital**	Name:	***Check as many as apply***	
Attn: **Medical Records**	Address:	Send to ☐	Mail ☐
Address: **1620 East 12th St.**		Receive from ☐	Fax ☐
Tulsa, OK. 74120	Phone: Fax:		Verbal ☐

MINIMUM NECESSARY INFORMATION TO BE RELEASED/SHARED for services from: _____ to _____

☐ Discharge Summary ☐ Psych Evaluation ☐ Treatment Plan(s) ☐ Psychosocial exam ☐ Progress Notes ☐ Medication sheets ☐ Other specify):__ _____

PURPOSE (CHECK): ☐ Treatment/consult ☐ Patient use ☐ Verify treatment ☐ Other: _____

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE.

DRUG AND/OR ALCOHOL ABUSE, AND/OR PSYCHIATRIC, AND/OR HIV/AIDS RECORDS RELEASE:

Information in your medical record that you have or may have a communicable or noncommunicable disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court or the Department of Health, disclosure among health care providers or disclosure for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court, by the Department of Health or by law.

I UNDERSTAND THAT:

- If my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information. I agree to its release: _____ ***initials***
- I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
- I understand that if my records contain alcohol and /or drug treatment information and I am legally considered a minor, I am the responsible individual that must authorize this disclosure (per 63 Okla.Stat. 2602).
- I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically in 6 months or as follows: _____.
- I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations. I will not be denied services if I refuse to consent to a disclosure for other purposes.
- I have been provided a copy of this form.
- I may inspect or copy the protected health information to be used or disclosed.
- **Payment for records is required in advance of receipt of records**.

I authorize the above-named entity to use and disclose the confidential and protected health information specified above:

Signature: _____ Date/time: _____ _____:_____

Signature of person signing form if not patient: _____ Authority: _____

Identity verified via: ☐ photo ID ☐ matching signature ☐ other: _____ Staff signature: _____

Approval for release of Information ☐ Yes ☐ No _____Therapist Signature Date/Time_____

Approval for release of Information ☐ Yes ☐ No_____ Physician Signature Date/Time_____