

**Cedar Ridge**  
6501 N.E. 50<sup>th</sup> Street  
Oklahoma City, OK 73141  
Telephone (405) 605-6111  
Fax (405) 424-0457

**AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION**

Print Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Previous/Other Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Patient Address: \_\_\_\_\_ Medical Record Number: \_\_\_\_\_  
\_\_\_\_\_ Telephone Number: \_\_\_\_\_

I authorize Cedar Ridge to exchange my protected health information as directed below: (use reverse side to indicate multiple parties.)

1. Name and address of person or organization to whom disclosure is to be made:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Purpose of the use or disclosure: \_\_\_\_\_

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I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services even though I am protected by Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patients Records, 42 CFR Part 2, the Illinois AIDS Confidentiality Act, or the Mental Health and Developmental Disabilities Confidentiality Act. A request in writing must be made to exclude the above from the disclosed information.

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I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department, I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by the laws and regulations applicable to Cedar Ridge. However, the recipient may be prohibited from disclosing substance information under the Federal Substance Abuse Confidentiality Requirements. I understand that I have the right to inspect and copy the information to be disclosed.

I understand authorizing the use or disclosure of the information identified above is voluntary. Healthcare treatment, payment, enrollment in a health plan, or eligibility for benefits is not conditioned on signing the authorization. Beyond this, my refusal to consent may have the following consequence – failure to disclose information.

There may be a fee associated with the processing of this request. Please check with Health Information Management Staff for the amount of any associated fees.

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This authorization expires on \_\_\_\_\_, 20\_\_\_\_, or upon event of \_\_\_\_\_

If no date or event is stated above, this authorization will expire 180 calendar days after the date of execution.

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Patient signature **REQUIRED FOR AGE 12 AND ABOVE**

\_\_\_\_\_  
(and Parent/Guardian/authorized signature where applicable)

\_\_\_\_\_  
(relationship if not patient)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

This authorization for Use of Disclosure Of Protected Health Information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards of Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164 and all federal regulations and interpretive guidelines promulgated thereunder. Any information protected by Federal Regulations governing substance abuse treatment (42 CFR, Part 2) or the Illinois Mental Health and Developmental Disabilities Confidentiality Act is prohibited from further disclosure unless further disclosure is expressly permitted by the written consent of the person to whom it pertains. A general authorization for release of medical or other information is not sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

PATIENTS 12 YEARS OF AGE AND ABOVE ARE REQUIRED TO SIGN.

Use this side if multiple parties are being requested to release medical information.

I authorize the following parties/agencies to exchange information contained in my patient records.

<b>Name and Address</b>	<b>Pt. initials/date</b>	<b>Parent/Guardian (when applicable)/date</b>	<b>Witness/date</b>
To: Address:			
To: Address:			
To: Address:			
To: Address:			
To: Address:			
To: Address:			
To: Address:			
To: Address:			
To: Address:			