AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my health information as described below.

Patient's name: ____________________________________ Date of Birth: ____________________________

Persons/organizations **providing** the information:

____

____

____

____

Persons/organizations **receiving** the information:

HEARTS for HEARING
3525 NW 56th, Suite A-150
Oklahoma City, OK 73112
Ph) 405.548.4300 – Fax) 405.548.4350

Specific description of information (including dates):

____

What is the purpose of the use or disclosure?

For Continuum of Patient Care by HEARTS of HEARING service providers.

Section B: Must be completed only if the healthcare provider has requested the authorization

For office use only

Will the healthcare provider requesting the authorization receive financial compensation in exchange for using or disclosing the health information described below? ____YES ____NO

Section C: Must be completed for all authorizations

Pt. Initials: _____ I understand that I am entitled to a copy of this authorization after I sign it.

Pt. Initials: _____ I understand that this authorization will expire on: ________________________________

Pt. Initials: _____ I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively.

Pt. Initials: _____ I understand that if I have authorized the disclosure of health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected.

____ ________________________________

Signature of patient or patient's representative ***Date signed***

Printed name of patient's representative: ____

Relationship to patient: ____

Address for revocation: Your revocation will be effective once it is received at the following address:

Hearts for Hearing, 3525 NW 56th, Suite A-150, Oklahoma City, OK 73112

By Oklahoma law we are required to notify you that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).