

TULSA NEUROLOGY CLINIC – JAY K. JOHNSON, D.O.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME _____ SOCIAL SECURITY # _____

DATE OF BIRTH _____ MEDICAL RECORD # _____

I hereby authorize the use or disclosure of the Protected Health Information described below to be provided to or obtained by the following:

Name/Address of Individual/Facility/Company to RECEIVE PHI:

JAY K. JOHNSON, D.O.
TULSA NEUROLOGY CLINIC
7134 S YALE, SUITE 450
TULSA, OK 74136
PHONE: 918-743-2882
FAX: 918-745-0323

Name/Address of Individual/Facility to DISCLOSE PHI:

Information requested: _____

This information will be obtained, used, or disclosed for the following purposes only:

- Insurance Continued treatment Legal Per Patient/Patient Representative Request
Other (specify) _____

I understand:

- I may revoke this authorization at any time, in writing. However, revocation will not apply to information already retained, used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Rights. Unless revoked, the automatic expiration date will be six (6) months from date of signature or upon occurrence of the following event: _____
I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the PHI. The entity authorized to disclose the information will not be compensated by the recipient for such disclosure. Normal applicable fees, such as copy fees, may apply.
Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
I have the right to inspect the health information to be released, unless prohibited by law, and I may refuse to sign this authorization.
Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits on obtaining this authorization.
My medical information may indicate that I have a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and human immunodeficiency viruses (also known as AIDS.) I further understand that my medical information may indicate that I am or have been treated for psychological or psychiatric conditions or substance abuse.

Signature of Patient

Date

Signature of Patient's Personal Representative

Date

Description of Representative's Authority to Act for the Patient (power of attorney, court-appointed guardian, etc.)

NOTICE OF RIGHTS: Information in your medical records that you had or may have a communicable or venereal 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 exposure, disclosure pursuant to an order of the court or the Department of Health, disclosure among healthcare providers, or 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 order of the court, or the Department of Health, or by law.