Stillwater Cancer Center
A DIVISION OF STILLWATER MEDICAL
PARTNERING WITH OKLAHOMA CANCER
SPECIALISTS AND RESEARCH INSTITUTE
1201 W. 6TH AVE. STILLWATER, OK 74074
PHONE: (405)742-4930 FAX: (405)742-4917

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Identification

Printed Name: _____ Date of Birth: _____
Address: _____
_____
Social Security #_____ Telephone: _____

FOR OFFICE/NURSE USE ONLY:

Information to Be Released: Covering the Periods of Health Care

From (date) _____to _____
From (date)_____ to _____

Please check type of information to be released:

__Pertinent documentation __Operative Report __Lab results __Complete health record
__History and Physical __Consulting reports __Progress notes __EKG
__Discharge Summary __X-ray reports __X-ray films/images __EEG
__Photographs, videotapes __Complete billing file __Itemized bill __**All Records**
__Other, (specify) _____

Purpose of Request

____ Treatment or Consultation _____ At the request of the patient ___Billing or Claims payment
____ All____ Other (specify)_____

I, the undersigned authorize and request The Cancer Center, A Division of Stillwater Medical Center to: ___Release information to:___Obtain information from:

Name: _____
Address: _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS records Release

I understand that my medical or billing record may contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing; HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, and/or other sensitive information, I agree to its release:

Time Limit & Right to Revoke Authorization:

Except to the extent that action has already been taken in reliance on the authorization, at any time **I** can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at {1201 W. 6th St., Stillwater, OK 74074}. Unless revoked, this authorization will expire on the date above or one year from the date of signature unless otherwise specified.

Re-Disclosure

I understand that once information is released to the above named person or persons, my information may be subject to re-disclosure. I understand that I do not have to sign the authorization or payment for services will be denied if I do not sign this form unless it is for research-related treatments or provided solely to give information to a third party as specified under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. I **authorize Stillwater Cancer Center, A Division of Stillwater Medical Center, to use and disclose the protected health information specified above.**

I understand that if I authorize the release of Drug & Alcohol Abuse treatment records (such as from Center for Addictions) that those records are protected by Federal Law. The Authorization for Release of Information form does not authorize re-disclosure of medical information beyond the limits of this consent. Federal Law (42 CFR Part 2) for Alcohol/Drug abuse, prohibit information disclosed from records protected by this law from being re-disclosed, even to the patient, without the specific written consent of the patient or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is NOT sufficient for these purposes. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____
Signature of Patient or Representative Date

_____ _____
Representative's Relation to Patient Expiration Date