Stillwater Medical

Authorization for Access or Disclosure of Protected Health Information

☐ **STILLWATER MEDICAL** CENTER
P.O. Box 2408, 1323 W. 6th Avenue
Stillwater, OK 74076
405.742.5737

☐ STILLWATER MEDICAL–**Blackwell**
710 South 13th Street
Blackwell, OK 74631
580.363.9450

☐ STILLWATER MEDICAL–**Perry**
501 14th Street
Perry, OK 73077
580.710.3132

NAME OF PATIENT:	DATE OF BIRTH:
SOCIAL SECURITY NUMBER:	MEDICAL RECORD or ENCOUNTER NUMBER:

I hereby authorize Stillwater Medical Center and its duly authorized agents and employees to:

☐ **Disclose records to:**
Name:_____
Address:_____
_____
Phone:_____

☐ **Obtain records from other Provider:**
Provider:_____
Address:_____
_____
Phone:_____

Patient requested method of delivery:

☐ Mail: ☐ Home address listed above ☐ Other: _____
☐ Fax: _____
☐ E-Mail: _____
☐ Pick-up: ☐ Stillwater ☐ SM-Blackwell ☐ SM-Perry on _____ @ _____ AM / PM ☐ at Clinic on _____ @ _____ AM / PM
☐ Push Scanned Documents to Meditech Portal

Information authorized for disclosure or to be obtained:

___ History & Physical ___ Discharge Summary ___ Operative Report ___ ER Record ___ Consultation ___ Lab Reports
___ X-ray Reports ___ X-ray Images ___ Clinic Notes ___ Patient Portal ___ Other: _____
___ SMC Clinic Records: ___SSA ___SCC ___Onco ___OrthoOK ___ DBWC ___Pawnee ___ SMPC ___SMPC Peds ___ ENT
___Morrison ___Other:_____
___ Medical Information between _____ to _____

The information will be obtained, used, or disclosed for the following purpose only:

___ Insurance ___ Continued Treatment ___ Legal ___ At the request of the Patient or Patient's Representative
___ Other (specify)_____

I understand:

- I may revoke this authorization at any time. This 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 Practices. Unless revoked, the automatic expiration date will be twelve (12) months from date of signature or upon occurrence of the following event:
_____.
This authorization is valid for 1- year for the above requested information only and/or for ongoing treatment related to the same condition.
- I understand Proxy access will remain in effect unless revoked or the minor child reaches 18 years of age. I may revoke this Proxy's access at any time by written notice per the Stillwater Medical Patient Portal Terms of Use. I further understand, if the child desires to continue this proxy access beyond their 18th birthday, the child must complete the Proxy Request Form as an adult.
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information. 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.
- I understand access to medical records is not guaranteed for psychotherapy notes. Access and disclosure of psychotherapy notes to the patient and/or patient representative requires approval by the licensed practitioner treating the patient.
- 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, and enrollment in a health plan, or eligibility for benefits on obtaining this authorization.

I UNDERSTAND THAT MY MEDICAL INFORMATION MAY INDICATE THAT I HAVE OR HAVE NOT BEEN TREATED FOR PSYCHOLOGICAL OR PSYCHIATRIC CONDITIONS OR SUBSTANCE ABUSE.

_____ _____
SIGNATURE (PATIENT OR LEGAL REPRESENTATIVE) DATE

_____ _____
PRINT NAME CAPACITY OF LEGAL REPRESENTATIVE (IF APPLICABLE)

HOSPITAL USE ONLY:

For Sensitive Documents or Behavioral Visits prior to 04.05.21:
☐ Release any requested records.
☐ Redact the following information before disclosure:
_____

Verify for all Patients:
☐ ID Checked OR
☐ Signature Verified

Comments:
_____

_____
PHYSICIAN SIGNATURE DATE TIME

11/1/22