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

LEGAL NAME OF PATIENT:	NAME AT TIME OF TREATMENT (IF DIFFERENT):	
SOCIAL SECURITY NUMBER:	MEDICAL RECORD or ENCOUNTER NUMBER:	DATE OF BIRTH:

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

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

OR

☐ **Obtain records from another provider:**
Provider:_____
Address:_____
_____
Phone:_____

Patient requested method of delivery:

☐ Mail: ☐ Address listed above ☐ Other: _____
☐ Fax: _____
☐ E-Mail: _____
☐ Pick-up: ☐ Stillwater ☐ SM-Blackwell ☐ SM-Perry on _____ @ _____ AM / PM ☐ at Clinic on _____ @ _____ AM / PM

Information authorized for disclosure or to be obtained:

☐ History & Physical ☐ Discharge Summary ☐ Operative Report ☐ ER Record ☐ Consultation ☐ Lab Reports ☐ Clinic Records
☐ X-ray Reports ☐ X-ray Images ☐ Patient Portal ☐ Psychotherapy Notes ☐ Substance Use Disorder Counseling Notes
☐ Entire Medical Record ☐ Other: _____
For SMCA Clinic Records (specify clinic or provider): _____
☐ Medical records related to the diagnosis or treatment of:_____ OR ☐ Dates of treatment from _____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 (1) year from date of signature or upon occurrence of the following event:
  _____
- This authorization is valid for the above requested information only or for ongoing treatment related to the same condition for one (1) year.
- The information requested may include reproductive or potentially related reproductive health care information.
- The 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 use 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.
- Access to medical records is not guaranteed for psychotherapy or substance use counseling notes, if any. Access and disclosure of psychotherapy notes or substance use counseling 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 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.

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

_____ _____
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: _____

_____
PHYSICIAN SIGNATURE DATE TIME

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

Comments: _____

12/1/25