**STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)**

1. **INDIVIDUAL INFORMATION** (FOR PERSON WHOSE INFROMATION WILL BE SHARED)

Name Date of Birth

Address

Phone Number

1. **SCOPE & PURPOSE FOR SHARING INFORMATION**

I understand protected health information is information that identifies me. The purpose of this authorization is to allow Norman Gastroenterology Associates to share my protected health information.

1. **AUTHORIZATION & INFORMATION TO BE SHARED**

I authorize Norman Gastroenterology Associates as set forth below, to share my protected health information for reasons in addition to those already permitted by law.

1. Persons/Organizations Authorized to Receive My Information:

 (Name, Address, Phone & Fax) Relationship Purpose

1. Information to be shared
2. Check one or more boxes below.
* Entire Medical Record (includes all records except Psychotherapy Notes)
* Psychotherapy Notes
* Mental Health Records
* Pathology Report
* Progress Notes
* EKG Report(s)
* Physician’s Orders
* Other
* History and Physical
* Consultation Report(s)
* Laboratory Report(s)
* Radiology Films
* Operation Report(s)
* Discharge Summary
* Radiology Report(s)
* Alcohol or Drug
* Abuse Records
1. Covering Services Between \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Insert either dates(s) or “all.”)
2. **EXPIRATION & REVOCATION**
3. This Authorization will Expire (must choose one):
* 3 years after last office encounter  Other (insert date or event): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
1. Right to Revoke

I understand I may change this authorization at any time by writing to the address listed at the bottom of this form. I understand I cannot restrict information that may have already been shared based on this authorization.

1. **ACKNOWLEDGEMENTS & SIGNATURES**
2. Acknowledgements
3. I understand this authorization is voluntary and will not affect my eligibility or benefits, treatment, enrollment, or payment of claims.
4. I understand if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulation may no longer protect the information.
5. I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request to the address listed at the bottom of the form.
6. I understand Norman Gastroenterology Associates, as a member of the Oklahoma Physicians Health Exchange (OPHX), may utilize an electronic network to exchange my protected health information with other providers unless I choose not to participate.
7. I acknowledge information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.
8. I have received a copy of the Notice of Privacy Practices. I have read and understand them; further, I understand I can ask any questions I may have about the notice of privacy practices at any time.
9. Signature

This document must be signed by the individuals or the individual’s legal representative.

Signature (Patient or Legal Representative) Date

Printed Patient or Legal Representative Name Capacity of Legal Representative (if applicable)

 **Physician / Clinic Address**: Norman Gastroenterology Associates 1515 North Porter Avenue, Suite 200 Norman, OK 73071