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

I. INDIVIDUAL INFORMATION (FOR PERSON WHOSE INFORMATION WILL BE SHARED)

Patient Label

II. 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.

III. AUTHORIZATION & INFORMATION TO BE SHARED

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

A. Persons/Organizations Authorized to Receive My Information (non-health persons or organizations):

Name	Relationship

B. Information to be shared

1. Check one or more boxes below.
   - ☐ Entire Medical Record (includes all records except Psychotherapy Notes)
   - ☐ Pathology Report
   - ☐ Laboratory Report(s)
   - ☐ Operation Report(s)
   - ☐ Discharge Summary

IV. EXPIRATION & REVOCATION

A. This Authorization will Expire (must choose one):
   - ☐ 3 years after last office encounter (Recommended)
   - ☐ ☐ Other (insert date or event): _____

B. 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.

V. ACKNOWLEDGEMENTS & SIGNATURES

A. Acknowledgements

1. I understand this authorization is voluntary and will not affect my eligibility or benefits, treatment, enrollment, or payment of claims.
2. 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.
3. 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.
4. I understand Norman Gastroenterology Associates participates with Oklahoma Physicians Health Exchange, Common well and Care Quality and may utilize an electronic network to exchange my protected health information with other providers unless I choose not to participate.
5. I acknowledge information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.
6. 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.

B. Signature: This document must be signed by the individuals or the individual's legal representative.

_____ Date: _____

Signature (Patient of Legal Representative)

NORMAN ENDOSCOPY CENTER Patient label

Authorization

AUTHORIZATION & INFORMATION TO BE SHARED

initial

I hereby authorize Norman Endoscopy Center to disclose any or all information in my medical record, including demographics, to any person, corporation, or agency for the purposes of billing, diagnosis, and/or treatment of health conditions. I acknowledge that protected health information may also be released for reasons permitted by law, such as a court subpoena. The information authorized for release may include the presence of a communicable or venereal disease, which may include but is not limited to, diseases such as hepatitis, syphillis, gonorrhea, the human immunodeficiency virus (HIV), and acquired immunodeficiency syndrome (AIDS).

PAYMENT OF MEDICAL BENEFITS

initial

I hereby request payment of medical benefits to Norman Endoscopy Center, to be paid directly by my insurance company(s).

ADVANCE DIRECTIVE

initial

Do you have an Advance Directive, Living Will, or Health Care Power of Attorney? ❑ yes or ❑ no
If yes, did you bring a copy? ❑ yes or ❑ no
If no, would you like more information on an Advanced Directive? ❑ yes or ❑ no

I hereby acknowledge that Norman Endoscopy Center informed me of their policy regarding Advance Directives. I understand that while a patient at Norman Endoscopy Center, in the event of medical emergency, life saving interventions will be done regardless of the verbage in my Advance Directive. In the event I am transferred to Norman Regional Health Systems my Advance Directive will accompany me. A official State of Oklahoma Advance Directive forms are available at patient request.

RECEIPT OF PRIVACY PRACTICE, PATIENT'S RIGHTS, AND PATIENT'S RESPONSIBILITIES

initial

I hereby acknowledge receipt of Norman Endoscopy Center's Notice of Privacy Practices, Patient's Rights, and Patient's Responsiibilities.

EHX CONSENT

EHX is the Norman physician hospital exchange. This allows medical records to be shared between Norman Regional Health System and the physicians that practice medicine there.

I authorize the following information to be shared via EHX, or fax, to PCP or specialist: initial

❑ Entire medical record *(includes all records except psychotherapy notes)*	❑ Do not share Medical Records

Information regarding TODAY'S visit may be released to the following person(s):

Name:	phone #

Detailed information about my procedure (results) or inquiries about my well being:

❑ May be left on the following voicemail _____

❑ I do not authorize any message to be left on my voicemail.

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. I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment of claims. I understand if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information. 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 this form. NORMAN ENDOSCOPY CENTER 1515 N. PORTER SUITE 100 NORMAN, OK 73071

MY SIGNATURE BELOW ACKNOWLEDGES THAT I HAVE READ THE ABOVE REQUIRED INFORMATION. THIS SIGNATURE _____ DATE_____