**Paul Firth, M.D., F.A.A.P**. A Professional Corporation Board Certified American Academy of Pediatrics

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OKLAHOMA STANDARD AUTHROIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

Patient’s Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Person/Organization **Disclosing** PHI

I hereby authorize \_\_\_\_\_\_\_\_\_\_\_Paul Firth, M.D.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Person/Organization **Receiving** PHI

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Information to be shared**:

Entire Medical Record

Mental Health Records

Immunization Record Only

Medical information compiled between \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The information may be disclosed for the following purpose(s) only:**

Continued Treatment

Legal

Insurance

At my or my representative’s request

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I understand that by voluntarily signing this authorization:**

* I authorize the use or disclosure of my PHI as described above for the purposes listed
* I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
* I have the right to receive a copy of this authorization
* I understand that unless the purpose of this authorization is to determine a payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims
* My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea, or HIV or AIS and /or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse
* I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI
* I understand I cannot restrict information that may have already been shared based on this authorization
* Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protect by the Privacy Regulation

Unless revoked or otherwise indicated, this authorization’s automatic expiration date will be one year from the date of my signature or upon the occurrence of the following event:

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Signature of Parent or Legal Representative Date

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Description of Legal Representative Authority Expiration Date (if longer than one year from date of signature or no event is indicated)