Tulsa Family Development Center

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

______________________ ______________ ______________ __________
Patient Name Date of Birth Social Security # Chart #

I hereby freely and voluntarily authorize Tulsa Developmental Pediatrics and Center for Family Psychology to:

_____ Release/disclose my protected health information to:
_____ Obtain my protected health information

____
Individual, Facility or Organization Phone #

____
Address Fax #

____
City, State and Zip Code

The purpose of this disclosure is for:

____insurance purposes ____educational placement ____medical treatment
____ continued treatment ____the patient ____progress updates
____other (explain) ____

Information to be used or disclosed:

____Discharge summary ____Psychiatric evaluation ____History & Physical
____Psychological Testing ____Substance abuse ____Psychosocial assessment
___Progress report ____Other (explain) ______________________________

I understand that my medical records may contain information regarding testing, and/or alcohol diagnosis and treatment, a communicable, noncomunicable or venereal disease which may include but is not limited to, diseases such as hepatitis, Syphilis, gonorrhea, or human immunodeficiency virus, also know as acquired immune deficiency syndrome (AIDS) and/or tuberculosis. I understand that such information is confidential and protected by federal law. I understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the disclosure or use of my health information purposes other than for treatment, payment and health operations. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the federal HIPAA law. I understand that I have the right to revoke this authorization at any time by giving a written notice to Tulsa Developmental Pediatrics & Center for Family Psychology's Privacy Officer, except to extent that action has already been taken in reliance on it. **This authorization will expire 180 days ( ) following discharge, or ( ) following signature** unless another date or condition is specified. Other date or condition specified______________________

Signatures:

____ ____________________
Patient- When applicable by law or clinic policy Date

____________________________ ____________ ____________________
Guardian or Representative Date Relationship to patient

____I agree to the following information being released.
____I Disagree to the release of information to the patient because: ______________________.

I, a representative of TDP & CFP, have discussed the issues above with the client and/or his or her representative. My observation of his or her behavior and response give me no reason to believe that this person is not fully competent to give informed and willing consent.

________________________________ ______________________
Signature of TDP & CFP Representative Date