



AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1. Primary Member Name: _____ Date of Birth: _____ SS# _____

2. Dependents: _____

3. I _____ hereby authorize
(Member, Legal Representative, Spouse or Dependent age 18 or over)

4. _____
(Name of Provider/Plan/or entity providing records)

to disclose specific health information from the file records of the above named member and/or dependents if applicable to:

5. _____
(Recipient Name/Address/Phone/Fax)

for the specific purpose(s):

6. _____

Specific information to be disclosed:

7. _____

I understand that this authorization will expire on the following date, event or condition:8. _____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year. I also understand that I may revoke this authorization at any time and that I will be asked to sign a **REVOCATION of AUTHORIZATION TO DISCLOSE HEALTH INFORMATION** form, which will be provided to me by OSEEGIB upon request. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding and that if this Authorization is used by OSEEGIB that no compensation is payable to OSEEGIB for this Authorization.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal or State Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law. **I understand the information authorized for release may include records which may indicate the presence of a communicable or noncommunicable disease.**

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

By signing this form, I understand and agree that I am responsible for any fee charged for copies of the medical information or records by the providing entity, and OSEEGIB is not responsible for payment of any fee charged for copies of medical records, report or any other documentation.

I further understand that I may request a copy of this signed authorization.

Return to OSEEGIB, 3545 NW 58th, Suite 100, Oklahoma City, Oklahoma 73112

9. _____ Date _____
(Signature of Member, Legal Representative, Spouse or Dependent age 18 or over)

Instructions for Authorization to Disclose Health Information

- 1. Enter the primary member's name, date of birth, and social security number.**
- 2. If the authorization is for a dependent(s), enter the dependent's name(s).**
- 3. Enter the name of the member, legal representative, spouse or dependent giving authorization to release information.**
- 4. Enter the name of the provider or plan being given authorization to release the information.**
- 5. Enter the name, address, telephone number, and fax number (if applicable) of the person or entity receiving the information.**
- 6. Enter the purpose for which the information is to be used.**
- 7. Enter the specific information that is to be released.**
- 8. Enter the date, event, or condition that the authorization is to expire.**
- 9. Member, legal representative, spouse or dependent age 18 or over must sign and date the authorization form.**