Janet Borden, LCSW PLLC
2202 E 49th St Ste 400
Tulsa, OK 74105
Office 918-749-1840 Fax 918-451-9672

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PERSON WHO'S INFORMATION WILL BE SHARED

PATIENT NAME (LAST, FIRST, MIDDLE)	AGE	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER

ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER

I understand protected health information is health care information that identifies me. The purpose of the authorization is to allow the sharing of my protected heath information.

I voluntarily authorize and request disclosure or the following records, orders, information, and/or reports (including paper, oral, and electronic interchange):

☐ Entire Record (excluding psychotherapy notes)

☐ Psychological ☐ Educational ☐ Health Related Information

☐ Medical ☐ Employment ☐ Psychotherapy Notes (No other box may be checked)

☐ Other: _____

Purpose of Request:

☐ Continued Treatment; ☒ Insurance; ☐ Referral; ☐ Legal; ☐ Patient's Request; ☐ Other _____

This includes specific permission to release:

1. All records and other information regarding treatment, hospitalization, and outpatient treatment and care, including, but not limited to: Psychological, psychiatric, or other mental impairments, (excluding psychotherapy notes as defined in 45 CFR 164.501); Drug abuse, alcoholism, or other substance abuse (42 C.F.R. SS2.34 and 2.35); Sickle cell anemia; Genetic testing information, [Health and safety code S124980(i)]; Records which may indicate the presence of a communicable or venereal disease which may include diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as acquired immune deficiency syndrome, (AIDS), and tests for HIV. Records might also include information about noncommunicable diseases such as diabetes, heart disease, obesity, arthritis, etc. [Health and safety code S120980(g) and OK statute TIL63 §1-502.2]
2. Information about how my or my child's health or impairments affect ability to complete tasks and activities of daily living, ability to participate in educational activities, and/or ability to work .
3. Information created within 12 months after the date this authorization is signed, as well as past information.
4. Exclusions: _____

I authorize the Person/Organization below to receive my protected health information.

Records ___To/___From:	Records ___To/___From:
Janet Borden, LCSW	Name:
2202 E 49th St Ste 400	Street:
Tulsa, OK 74105	City, State, Zip
Office: 918-749-1840	Phone:
Fax: 918-451-9672	Fax:

Right to Revoke I understand I may change this Authorization at any time by writing to: Janet Borden, LCSW, PO Box 140903. Broken Arrow, OK 74014. I understand I cannot restrict information that may have already been shared based on this Authorization. Once private health information is disclosed to others, , it may be re-disclosed by them to persons or entities that are not subject to the privacy regulations, which means that the private health information may no longer be protected by regulations.

Acknowledgements

- This authorization will expire one year from the date signed unless revoked in writing.
- I understand that 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 and it is no longer protected by federal law.
- The practice will not condition treatment or payment based on my signing this authorization.
- No one has pressured me to sign this authorization
- I acknowledge that I have had an opportunity to review this authorization and understand the intent and the use.
- I acknowledge information authorized for release may include records which may indicate the presence of a communicable or noncommunicable disease, including but not limited to diseases such as venereal disease, hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE:	RELATIONSHIP:	DATE:

PRINTED NAME OF PATIENT'S REPRESENTATIVE: