EDMOND PSYCHIATRIC ASSOCIATES
2000 Sonoma Park Drive
Edmond, OK, 73013
Jennifer Morris, MD
Lyndsey Jones APRN, CNP
Chester Hendershot, PA-C

HIPAA – AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ DOB: _____

Social Security Number: _____ Phone: _____

- I authorize the use or disclosure of my individual health information as described below:
- The following individual or organization is either **AUTHORIZED or UNAUTHORIZED** (please circle one) to disclose protected information: Please list the Name, Doctor, family member or facility and phone number:

Name	Relationship	Phone / Fax
_____	_____	_____
_____	_____	_____
_____	_____	_____

The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

O Entire Chart
O Most recent chart or Doctors notes
O Laboratory results
O Medication list
O Most recent history & physical
O Letter Only (given to patient to hand to the above) ☐
O Billing Only

O Consultation Between _____ & Dr. Morris/Chester Hendershot, PA C/Lyndsey Jones, CNP

O Other _____

- I understand that the information in my health record may include information relating to communicable or non-communicable disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- This information may be disclosed to and used by the following individuals and/or organization:

☐ **Dr. Jennifer Morris/Chester Hendershot, PA-C/Ashley Burns, CNP**

- I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.
- ☐ Mark box if no expiration is desired. ☐ Mark box if this expires on patient's 18 birthday.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact **Edmond Psychiatric Associates** at (405) 285-2260 or by fax at (405)285-2280.
- I understand information will be faxed at no charge and copies will be charged at standard rates.

_____ _____ _____
Signature of Patient or Legal Representative Relationship to Patient Date