

08HI003E-001



OKLAHOMA DEPARTMENT OF HUMAN SERVICES



Authorization to Disclose Medical Records

I, (client's name) give permission for the Department of Human Services County to give my health care records described below to:

The Oklahoma Work Incentive Planning and Assistance Project
for the following purposes: Employment Planning

By initialing the spaces below, I specifically give permission to release the following health information:

Client or client's personal representative must initial next to the information to be released.

HIV/AIDS related information and records	_____	History and physical	_____
Mental health records	_____	Discharge summary	_____
Genetic testing and records	_____	Operative report	_____
Drug/alcohol abuse information	_____	X-Rays	_____
Pathology	_____		

Other XX Specify: Proof of Eligibility for Medical/Medicaid, Food Stamps & TANF. **Please Initial X**

Specific service date(s) or event(s): Present

NOTICE

The information I authorize for release may include records which may indicate the presence of a communicable or non-communicable disease.

I understand information in my records that I have or may have a communicable or non-communicable disease is made confidential by law and cannot be released without my permission except in limited circumstances, including release to the persons who have had risk exposures, release pursuant to an order of the court or the Oklahoma State Department of Health (OSDH), release among health care providers or release for statistical or epidemiological purposes. When such information is released, it cannot contain information from which I could be identified unless release of that identifying information is authorized by me, by an order of the court, or OSDH by law.

I understand that if the person or organization who gets my health information is not covered by federal privacy regulations, my information may be redisclosed and no longer

protected by those regulations. However, even if the person or organization is not covered by federal privacy regulations, they may be prohibited from disclosing. I also understand that I do not have to sign this form. If I do not sign this form, it will not keep me from getting treatment, payment, or an eligibility decision. I understand that I can look at and copy any information released under this release.

I understand that I can take back my permission to release information. If I want to do this, it has to be in writing, but I cannot take back my permission for information that has already been released. Unless I take back my permission sooner, this authorization will expire in 180 days or _____

_____ Signature of client or client's representative	_____ Date
_____ Print client's name	_____ Client date of birth
_____ Print name of legal representative, if applicable	_____ Relationship to client