C:\Documents and Settings\katie.canterbury\Local Settings\Temporary Internet Files\Content.IE5\5AA30OD3\MC900018849[1].wmf

ONLY FILL THIS FORM OUT IF YOU WOULD LIKE SOMEONE

(i.e. spouse, child, parent, etc.) TO BE ABLE TO RECEIVE INFORMATION ON YOU, OR YOUR ACCOUNT, FROM OUR OFFICE.

Thank You.

Charles C. Carter, MD DPh

Authorization to Disclose Protected Health Information

1. **Individual (information of patient authorizing disclosure):**

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TELEPHONE #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and relationship of person authorizing disclosure if other than patient (Must be parent, legal guardian, or have Power of Attorney)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Authorization:**

I request and authorize Charles C. Carter, MD DPh to disclose m protected health information as described below. I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

Persons/Organizations authorized to receive your information Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

\*Please attach a copy of a picture ID with each person/organization you have listed above

**III. Specific Description of Information to be Used or Disclosed (check one or more):**

|  |  |
| --- | --- |
| * Insurance Information | Includes co-payments, coinsurance, eligibility, payment of claims for services rendered, precertification, authorization for services, referrals, and any other information pertaining to insurance. |
| * History & Medical Information | Includes information related to diagnosis, appointments, services rendered, test or pathology reports, consult or referral documentation, and any other information pertaining to a patient’s history or medical portions. |
| * Billing Information | Includes payments received, unapplied balances, unpaid balances, charges billed, and any other information pertaining to billing. |
| * Other (Specify other information authorized for disclosure) |  |

This Authorization CANNOT be used to disclose Psychotherapy Notes

1. **Expiration and Revocation:**

Expiration: This authorization will expire on (must choose one):

* One year from the date it is signed
* On the following date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. I understand that revocation of this authorization will not affect any actions from the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.

1. **Signature**

I acknowledge that, in accordance with state law, the information authorized for disclosure may information which may be considered a communicable or venereal disease, which may include, but is not limited to, disease such as hepatitis, syphilis, gonorrhea and Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator complete the following and attach a copy of the Legal Documents:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Representatives’ Name Relationship to Individual

P.O. Box 575

Altus, OK 735211

For questions or concerns please call:

(580) 480-1600 option #6