Shadow Mountain Behavioral Health System
6262 South Sheridan, Tulsa, Oklahoma 74133 Phone: 800-821-6993 Fax: 918-493-3294

Authorization to Use or Disclose Protected Health Information

Patient Name:_____
Date of Birth:_____SSN:_____
Dates of Treatment:_____

I hereby freely and voluntarily authorize Shadow Mountain Behavioral Health System to:
_____Obtain my protected health information from:
_____Release/ disclose my protected health information to:

Individual, Facility, or Organization	Phone Number	Fax Number

Address	City	State	Zip

The purpose of this disclosure is for:

___Insurance purposes	___Educational placement	___Legal reasons
___Medical treatment	___Discharge planning	___Continued treatment
___Progress updates	___The patient	___Other_____

Information to be used or disclosed:

___Dr's Discharge Summary	___Psychiatric Evaluation	___Mental Status	___History & Physical
___Psychological Testing	___Treatment Plans	___Lab/X-ray results	___Progress Reports
___Psychological Assessment	___Immunization status	___Physician Orders	___Substance Abuse Tx
___Aftercare Plan	___Discharge Instructions	___Other_____	

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE, or related to mental health, testing, drug, substance, and/or alcohol diagnosis and treatment. I understand that such information is confidential and is protected by federal law. I understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the disclosure or use of my health information for purposes other than for treatment, payment, and healthcare operations. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the Federal HIPAA law. I understand that I have the right to revoke this authorization at any time by giving written notice to Shadow Mountain and/or other facility privacy officer, except to the extent that action has already been taken in reliance on it. The authorization will expire 180 days following discharge, or following signature date unless another date or condition is specified. Other date or condition specified:

SIGNATURES

Patient – When applicable by law or hospital policy		Date
Guardian or Representative	Relationship to Patient	Date
Witness		Date

***Drug and alcohol records are protected by Federal confidentiality ruling (42 CFR part 2)** and require written consent to disclose this information unless otherwise permitted by 42 CFR part 2. Further disclosure is prohibited without written consent by the person to whom the information pertains unless otherwise permitted by the law. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

****Psychiatric Records:** Oklahoma State Law (760.S. Supp. 1986 Section 19) Provides that psychological or psychiatric records may be provided to a patient only if the treating practitioner consents to the release, or upon a court order issued by a court of competent jurisdiction.

DO NOT USE ** SHADOW MOUNTAIN BEHAVIORAL HEALTH SYSTEM'S PHYSICIAN USE ONLY **
_____I agree to the information being released.
_____I disagree to the release of information
Doctor and/or Therapist Signature(s): **Date**

A copy of this authorization can be provided to the person signing it.