

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:

<input type="checkbox"/> Insurance purposes	<input type="checkbox"/> Educational placement	<input type="checkbox"/> Legal reasons
<input type="checkbox"/> Medical treatment	<input type="checkbox"/> Discharge planning	<input type="checkbox"/> Continued treatment
<input type="checkbox"/> Progress updates	<input type="checkbox"/> The patient	<input type="checkbox"/> Other _____

Information to be used or disclosed:

<input type="checkbox"/> Dr's Discharge Summary	<input type="checkbox"/> Psychiatric Evaluation	<input type="checkbox"/> Mental Status	<input type="checkbox"/> History & Physical
<input type="checkbox"/> Psychological Testing	<input type="checkbox"/> Treatment Plans	<input type="checkbox"/> Lab/X-ray results	
<input type="checkbox"/> Psychological Assessment	<input type="checkbox"/> Immunization status	<input type="checkbox"/> Substance Abuse Tx	
<input type="checkbox"/> Aftercare Plan	<input type="checkbox"/> Discharge Instructions	<input type="checkbox"/> 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.

Shadow Mountain Behavioral Health System is now closed as of June 2019

Please contact UHS-NRO for all Records requests:

UHS-Nashville Regional Office 1000 Health Park Dr. Bldg. 3 Ste. 400 Brentwood, TN 37027	Email: nrorecordsrequests@uhsinc.com Fax: 615-997-1200
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