AUTHORIZATION FOR ACCESS BY PATIENT OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION

Patient Name:_____ Medical Record No.:_____

Date of Birth:_____ Social Security No.:_____

I hereby authorize the use of disclosure of the Protected Health Information (PHI) described below To be provided to or obtained by the following:

Name of Individual to disclose PHI:

Kathy Bottroff, M.S., C.R.C., L.P.C.
PROS and Associates
3033 N.W. 63rd Street, Suite 101
Oklahoma City, OK 73116-3607

Information authorized for use, disclosure or to be obtained:

- ❑ All medical information concerning this patient.
- ❑ Medical information of this patient compiled between _____ to _____
- ❑ Only:_____

Dates of Treatment, if known: _____

The Information will be obtained, used or disclosed for the following purposes only:

- ❑ Insurance
- ❑ Continued treatment
- ❑ At the request of Patient or Patient's Representative
- ❑ Other (Specify): _____

I understand:

- I may revoke this authorization at any time, except revocation will not apply to information already used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Practices. Unless revoked or otherwise indicated, the automatic expiration date will be one year from the date of my signature or upon occurrence of the following event: _____
- I release the entities listed above, their agents and employees from any liability in connection with the use of disclosed protected health information covered by this authorization. The entity authorized to disclose the information will not be compensated by the recipient for the disclosure, except for the cost of copying and mailing as authorized by law.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- I have the right to inspect the health information to be released and I may refuse to sign this authorization.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment of payment for my care on my signing this authorization.

I understand that my medical information may indicate that I have a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea or the human immunodeficiency virus, also know as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Description of Legal Representative's Authority Expiration Date

NOTICE OF RIGHTS: Information in your medical record that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an Order of the Court of the Department of Health, disclosure among health care providers or disclosure for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure or that identifying information is authorized by you, by an Order of the Court or the Department of Health or by law.