



OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS OR FRIENDS

Many of our patients allow family members and friends to call and request information related to appointments, medical, prescriptions or billing. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have this type of information released, including prescription pick-up, this form must be signed. Signing this form will only give consent to release this information to the family members or friends indicated below. This authorization shall be in force and effective for the duration of 12 months from date of signature, at which time this authorization will expire.

You have the right to revoke this consent in writing.

I authorize/allow Oklahoma Cancer Specialists and Research Institute to release my information to the following individual(s):

_____	Relation to Patient _____	Phone _____
_____	Relation to Patient _____	Phone _____
_____	Relation to Patient _____	Phone _____

II. ACKNOWLEDGEMENTS AND SIGNATURES

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| A. I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment of claims. | D. I acknowledge information authorized for release may include records, which may indicate the presence of a communicable or non-communicable disease. |
| B. I understand if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information. | E. Right to Revoke – I understand I may change this authorization at any time by writing to Oklahoma Cancer Specialists and Research Institute. I understand I cannot restrict information that may have already been shared based on this authorization. |
| C. I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request to Oklahoma Cancer Specialists and Research Institute. | F. This document must be signed by the patient or the patient's legal representative. |

Patient or Legal Representative

Signature: _____ Date: _____

Printed Name: _____ Relationship to patient: _____
(if applicable)

Account Number: _____

AUTHORIZATION REQUIREMENTS FOR USE & DISCLOSURE POLICY, Authorization Form, Revised: July 2012. HIPAA Document—retained for a minimum of 6 years. Copy to Requester as required.