

Authorization for Disclosure of Protected Health Information

I, _____, authorize the disclosure of my protected health information¹ as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws², subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

1. I authorize the following person(s) and/or organization(s) to disclose my protected health information(as specified below):

Name(s): _____

Organization(s): _____

Address: _____

2. I authorize the following person(s) and/or organizations to receive my protected health information as disclosed by the person(s) and/or organizations(s) above.

**Consolidated Benefits Resources, L.L.C.
P.O. Box 581630, Tulsa, OK 74158-1630**

3. Specific description of the protected health information that I authorize for disclosure:
Treatment notes, diagnostic test results, history/physical notes, narrative reports, billing data.

4. Specific description of the purpose for each use or disclosure:
Workers' Compensation Benefits

5. I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization.

6. I understand the information released may include information that may indicate the presence of communicable or venereal diseases which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the Human Immune Deficiency Virus also known as Acquired Immune Deficiency Syndrome("AIDS").

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction.

Signed _____ Date _____

Name: _____

Address: _____

Telephone: _____ Social Security No.: _____

Relationship or Authority of Personal Representative (if applicable) _____

This Authorization to disclose PHI constitutes a waiver of privilege per 76 O.S. §19. Photostatic copies of this Authorization carry the same authority as the original.

¹ Protected health information ("PHI") is health information that is created or received by a health care provider, health plan, or health care clearing house which relates to: 1) the past, present or future physical or mental health of an individual; 2) the provision of health care to an individual; or 3) the past, present, or future payment for the provision of health care to an individual. To be protected, the information must be such that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual. 45C.F.R.164.508

² These laws apply to health plans, health care providers, and health care clearinghouses.