

Roger Hicks & Associates Group Insurance, Inc.

P.O. Box 18169, Oklahoma City, OK 73154-0169
Office 405.478.3836, Fax 405.478.3636

Employee Authorization for Disclosure Of Protected Health Information

Federal regulations, called the HIPAA Privacy Rule, provide important protections for your health information. The Privacy Rules apply to the use and disclosure of this protected health information by health care providers, health plans and health care clearinghouses. These covered entities may not require you to provide an authorization for treatment, payment or health care. However, they must obtain your authorization for disclosure and use for other purposes. In order that we may obtain health information about you from your health care provider, you will need to complete, sign and date this authorization form.

I, _____, _____, hereby authorize:
Patient Name Patient Birth Date

Name: _____ Provider/Hospital/Clinic: _____

Address: _____

its Director or designees, or Medical Information Services Department to release any and all information regarding my treatment or condition or contained in my entire patient record. (This authorization does not extend to psychotherapy notes, as that term is defined in the HIPAA Privacy Rules, 45 C.F.R. § 164.501, to mean notes recorded in any medium by a health care provider who is a mental health professional, documenting or analyzing the contents of conversation during private, joint or group counseling sessions, and which are kept separate from my medical record.) I specifically authorize you to disclose this information orally and to disclose my entire medical record.

1. Person(s) or organization(s) to who disclosure is to be made:

Name: _____ Organization: Roger Hicks & Associates Group Insurance, Inc.
Address: PO Box 18169, Oklahoma City, OK 73154 Phone: (405) 478-3836

2. Specific type of information to be disclosed (if more limited than designated above):

3. Purpose or need for disclosure: (provide reason or state "at my request")

4. This authorization expires: _____

This authorization is subject to written revocation at any time except to the extent that the health care provider has already taken action in reliance on the authorization. I understand that the information disclosed is subject to re-disclosure and will no longer be protected by the federal Privacy Rules, 45 C.F.R. Parts 160 and 164. (HIPAA Authorization 45 C.F.R. 164.508)

Signature

Date