ARKANSAS VERDIGRIS VALLEY HEALTH CENTERS, INC.(aka Porter Health Clinic)

505 S. Main St., Porter, OK 74454, (918)483-0111, Fax (918)483-0112

Authorization for Release of Information

Name (Please print clearly)_____ Social Security No._____

Date of Birth _____

Authorize: _____ to release to: Arkansas Verdigris Valley Health Centers, Inc.

Name of Person or Facility Releasing info.

505 S. Main St.

Porter, OK 74454, (918)483-0111

_____

Address of Person or Facility Releasing info.

The following information for the following dates of treatment: From: _____ To : _____

I understand that treatment services are NOT contingent upon or influenced by my decision to permit the information released. I also understand that I or my legally authorized representative may revoke this consent in writing at any time unless action has already been taken based upon it. I can do this by submitting a written request to the Medical Records Department. I freely and voluntarily give this consent.

I understand that the records requested may be protected under 42 C.F.R.,Part 2, governing Alcohol and Drug Abuse patient records the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. pts. 160 & 164, State Confidentiality laws and regulations and cannot be released without my consent unless otherwise provided for by regulations. State and Federal law regulations prohibit any further disclosure of such records without my specific written consent or when otherwise permitted by such regulation.

I ACKNOWLEDGE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NON-COMMUNICABLE DISEASE.

SPECIFIC INFORMATION REQUESTED

____LABS ____ DISCHARGE SUMMARY

____DIAGNOSTIC STUDIES ____ H & P

____DOCTOR'S NOTES ____ OPERATIVE NOTE ____OTHER

For the purpose of _____

I HEREBY AUTHORIZE THIS INFORMATION TO BE RELEASED BY : ___ MAIL ___ FAX ___ VERBAL ___ HAND CARRIED OR GIVEN

I UNDERSTAND THAT I AM UNDER NO OBLIGATION TO SIGN THIS FORM AND MY REFUSAL TO SIGN WILL NOT AFFECT THE ABILITY TO OBTAIN TREATMENT.

I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION IN WRITING AT ANY TIME PRIOR TO THE RELEASE OF THE INFORMATION SPECIFIED ABOVE. IF USED FOR ONGOING COMMUNICATION, THIS AUTHORIZATION EXPIRES IN TWELVE (12) MONTHS. DISCLOSURES MADE IN GOOD FAITH PRIOR TO REVOCATION DOES NOT CONSTITUTE A BREACH OF CONFICENTIALITY.

THIS AUTHORIZATION WILL EXPIRE:_____

1._____ _____

Signature Date Signature of Witness Date

2. _____ _____

Signature of authorized representative or parent or guardian when applicable Date Relationship to Consumer

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If the patient is a legally competent adult, he/she must sign this form. If he/she is a legally incompetent adult, it must be signed by the personal guardian (accompanied by proof of guardianship). If the patient is under the age of 18 years, the patient's parent or legal guardian must sign. (Signatures must be witnessed by at least one person.) If the patient is incompetent, and unable to sign, his/her mark or consent must be witnessed by at least two persons.

NOTICE TO RECIPIENTS OF INFORMATION: Any information disclosed to you pertaining to drug and/ or alcohol treatment was taken from records of which the confidentiality is protected by State and/or Federal Law. Federal regulations (42 CFR, Part 2) prohibit you from making any further disclosure of it without the specific, written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for release of medical or other information is not sufficient for this purpose. ALL BLANKS MUST BE COMPLETED TO BE VALID.

REVOCATION:

_____ _____

Signature Date Witness Date

A photocopy of this authorization shall be considered as valid as the original.