OSAG

Consent for Release of Protected Health Information

I, _____(Circle) Patient, Parent, Guardian, legal custodian of:

_____ SSN: ____ ____ ____ DOB:_____ _____ _____
(NAME OF PATIENT)

authorize the use or disclosure of the Protected Health Information described below to be provided to or obtained by the following:

Name of individual/company to receive PHI:

Workers' Compensation Claims
Consolidated Benefits Resources
P.O. Box 581630
Tulsa, Oklahoma 74158-1630

Name of individual/company to disclose PHI:

_____

_____

Information authorized for use or disclosure, or to be obtained:

☐ All medical information concerning this patient.

☐ Medical information of this patient compiled between the dates of _____and _____.

☐ Only:_____

The information will be obtained, used and/or disclosed for the following purpose(s) only:

☐ Insurance ☐ Continued treatment ☐ Legal ☐ At the request of the patient or patient's representative

☐ Workers' Compensation Benefits ☐ Other (specify) _____

Date Authorization expires: _____ (if no date is selected, this Authorization will expire in one (1) year from the date signed below).

I understand:

- I may revoke this authorization at any time, in writing, 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 to Claims Manager of Consolidated Benefits Resources.
- I release the entities listed above, their agents and employee from any liability in connection with the use or disclosure of the protected health information covered by this authorization. The entity authorized to disclose the information will be compensated by the recipient for the disclosure, except for the cost of copying and mailing as permitted by law.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure 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 or payment for my care on my signing this authorization.

The information I authorize for release may include records which may indicate the presence of a communicable or noncommunicable disease, or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS). I further understand that my medical information may indicate that I have been treated for psychological or psychiatric conditions or substance abuse.

_____ _____
Signature of Patient or Representative **Date** **Employer**

_____ _____
Representative's Relation to Patient **Employer Address**

_____ _____
Signature of Witness **Date** **Date Authorization expires**

Notice of Rights: Information in your medical records that you have or may have a communicable or noncommunicable disease 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 risk exposures, disclosure pursuant to order of a court or 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 of that identifying information is authorized by you, or by an order of a court or the Department of Health.

A COPY IS AUTHORIZED AS AN ORIGINAL