AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Name: _____ Birth Date ____/____/____

Address: _____

Telephone Number: (day) _____ (evening) _____ Lab No: _____

1. I hereby authorize Tulsa Medical Laboratory, LLC , to use or disclose the health information described in paragraph 2 below to the following individual of institution:

   Name:_____
   Address:_____
   Phone:_____

2. I hereby authorize the following health information to be used or disclosed:

   ___ Medical information of this patient compiled between _____to_____
   ___ Other (specify)
   _____
   _____
   _____
   _____

3. The information will be obtained, used, or disclosed for the **following purpose(s)** only:

   ___ Insurance ___ Continued treatment ___ At the request of the patient or patient's representative
   ___ Other (specify) _____

4. **I understand the following:**

   - I may revoke this authorization at any time, in writing, except revocation will not apply to information already detained, used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation to **Tulsa Medical Laboratory, LLC.** 2738 E. 51st Street, Suite 270, Tulsa, OK 74105. Subject to my earlier revocation, this authorization will be effective until the following date or event_____ If not otherwise indicated, the **automatic expiration date will be one (1) year from the date of signature.**
   - I release Tulsa Medical Laboratory, LLC.,its agents and employees from any liability in connection with the use or disclosure of the health information. Tulsa Medical Laboratory, LLC will not be compensated by the recipient for release of the information.
   - 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.

   I understand that the information authorized for release may include records which may indicate the presence of a communicable or noncommunicable disease.

   _____ _____
   Signature of Patient or Legal Representative

   _____
   Description of Legal Representative's Authority and Relationship to Patient

   NOTICE OF RIGHTS: Information in your medical record that you have or may have a communicable or noncommunicable disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court of 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, by an order of the court or the Department of Health or by law.