Authorization to Release Shared Protected Health Information

____

Last Name: _______________________________ First: ______________________ MI: ________________

Address: ____________________________________ City: ______________ State: ______ Zip:___________

Date of Birth: ______________________________ Phone: _____________________________________

I authorize ____ (my treating doctor or the treating facility full name) to share my entire medical record covering all services for reasons permitted by law.

Person/Organization Authorized to Receive my Information:

A. The University of Oklahoma, Department of Risk Management, 905 Asp Avenue, Room 112, Norman, OK 73019, Employer
B. Christensen Law Group, 3401 N.W. 63rd Street, Suit. 600, Oklahoma City, OK 73116, Employer Legal Representative and/or
C. Bonham & Howard, 3555 N.W. 58th Street, #1000, Oklahoma City, OK 73112, Employer Legal Representative and/or
D. CCMSI, 1501 North University, Suite 767, Little Rock, AR 72207, Employer Workers' Compensation Third-Party Administrator.

I understand:

- I may revoke this Authorization at any time by providing my written revocation to the address listed in "A" above. I understand my revocation will not apply to information already retained, used, or disclosed in response to 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.
- A photocopy or facsimile of this Authorization shall be as valid as the original.
- Information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Privacy regulations.
- I understand this Authorization also authorizes the release of any all medical records from any and all medical providers.
- I also authorize the production of my medical records before any Court of competent jurisdiction.
- My medical information may indicate that I have a communicable or venereal disease which may include, but not limited to, diseases such as hepatitis, syphilis, gonorrhea or the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).
- My medical information may indicate that I have, or have been treated for, psychological or psychiatric conditions or substance abuse.
- This Authorization will automatically expire in twelve (12) months of the date of the signature below.

____ **Date**: ____________________________

Employee Signature

(Updated June 2016)