MEDICINE

October 2022

AUTHORIZATION TO USE OR DISCLOSE SUBSTANCE USE DISORDER INFORMATION

Patient Name:_____ **Date of Birth:** _____
Last First Middle

Address:_____
Street Address City State Zip Code

Phone:_____ **Last 4 of SSN:** _____

I hereby authorize Oklahoma State University Center for Health Sciences ("OSU-CHS") and its duly authorized agents and employees to:

□ RELEASE or □ OBTAIN

the protected health information indicated below to/from:

Name:_____ **Phone:**_____ **Fax:** _____

Address: _____
Street Address City State Zip Code

Information to be Released/ Disclosed: Records between the dates of _____ and _____

_____
Nature of information, please be specific as possible

□ check here to release/disclose all behavioral health and substance use disorder information (e.g., diagnoses, medications, test results, substance use history, summaries of care, clinical notes, discharge summary, social support, living situation, billing information, etc.)

Purpose of the Requested Use or Disclosure:

_____
Indicate specific reason for disclosure

I understand:

- My substance use disorder records are protected under the federal regulations (42 CFR Part 2) and Oklahoma law (43A O.S. §1-101 et seq) governing confidentiality of substance use disorder patient records and cannot be disclosed without my written consent, unless authorized by law.
- I authorize OSU-CHS to disclose my substance use disorder information to the individuals and/or entities named above.
- I can cancel this authorization at any time by submitting a written cancellation request to OSU-CHS Compliance Office, 717 S. Houston Ave., Suite 510, Tulsa, OK 74127. The cancellation will not apply to information that has already been used or disclosed based on this authorization.
- I have the right to receive a copy of this authorization.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, HIV or AIDS and/or may indicate that I am being or have been treated for psychological or psychiatric conditions or substance abuse.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by privacy regulations.

Unless I specify a different date, event, or condition upon which I want this authorization to expire immediately below, this authorization automatically expires **one year** from the date of signature below.

Date, event, or condition upon which this authorization shall expire:_____
I voluntarily give my consent to the use and disclosure of individually identifiable health information and release OSU-CHS and its duly authorized agents and employees from any liability in connection with the use or disclosure of the information contained herein.

Signature of Patient or Legal Representative_____ Date: _____

Printed Name and Authority of Legal Representative (ifapplicable): _____

TRANSLATOR USE ONLY: This is to certify that the above Authorization has been read to the patient (or representative) in his/her native language and all representations which appear in the Authorization were understood and authorized by the patient (or representative)

Translator:_____ Date: _____

OKLAHOMA STATE UNIVERSITY
CENTER FOR HEALTH SCIENCES

1111 West 17th Street
Tulsa, OK 74107
health.okstate.edu

Important Notice Regarding Disclosure of Substance Use Disorder Records

Re: Disclosure of records pertaining to _____ [patient name]

This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.