BREAST SURGERY OF TULSA
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

I. PATIENT INFORMATION *(For Patient Whose Information Will Be Obtained or Released) – Please Print*

Name:_____ **Date of Birth:**_____
Address:_____ **City:**_____ **State:**_____**Zip:**_____
Area Code & Telephone Number:_____ **Date:**_____

I AUTHORIZE BREAST SURGERY OF TULSA TO: (CHECK ONE)

X Obtain Information from: ☐ **Release** Information to:

Name of Person(s), Provider, or Facility	Relationship	Name of Person(s), Provider, or Facility	Relationship
Warren Clinic—Breast Specialists at St Francis			
Address, City, State, Zip Code	**(AC) Phone No.**	**Address, City, State, Zip Code**	**(AC) Phone No.**
6475 S Yale Ave, Ste 400; Tulsa Ok 74136	918-502-9600		

If You Want Your Medical Information Released to ***Family Members or Friends****, Please List Names and Relationships Here*:

_____ _____
Name / Relationship *Name / Relationship*

_____ _____
Name / Relationship *Name / Relationship*

PURPOSE OF REQUEST: (*Please check appropriate box***)**

X Healthcare	☐ Insurance Coverage	☐ Legal	☐ Personal	☐ Other

INFORMATION TO BE OBTAINED OR RELEASED ***(****Please check all that apply****):***

X Medical Records	☐ Billing Records	☐ Other

IF OTHER, PLEASE BE SPECIFIC:_____

A. Covering Services Between____ ALL _____and_____*(Insert Dates or "all.")*

B. This Authorization will expire *(must choose one):*

X 12 months from the date signed ***…..OR….***	☐ Other

II. ACKNOWLEDGEMENTS AND SIGNATURES

A. I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.
B. I understand if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information.
C. I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request to Tulsa Cancer Institute.
D. I acknowledge information authorized for release **may include records, which may indicate the presence of a communicable or non-communicable disease.**
E. Right to Revoke – I understand I may change this authorization at any time by writing to Tulsa Cancer Institute. I understand I cannot restrict information that may have already been shared based on this authorization.
F. This document must be signed by the patient or the patient's legal representative.

_____**DATE:**_____
(Signature of Patient or Legal Representative)

_____**RELATIONSHIP TO PATIENT:**_____
(PRINTED Patient or Legal Representative Name) ***(If Applicable)***