Woodson Family Medical Clinic
Stigler, Oklahoma

Authorization to Release Protected Health Information

This form is to confirm your authorization to use or disclose your protected health information (PHI) for a special purpose. We want to follow your wishes. We apologize for any inconvenience.

1. PATIENT (OR REPRESENTATIVE) CONFIRMING THE AUTHORIZATION

I give my authorization to use or disclose my protected health information as described below. I give this authorization voluntarily.

Patient's name: _____

Address: _____

_____

Phone #: _____

2. THE USE AND/OR DISCLOSURE AUTHORIZED

Describe the type of PHI you are authorizing to be used and/or disclosed. "All information" (circle if desired) or give specific details.

_____

_____

Name the people and/or organizations (or the kind of people, like relatives) that you are authorizing to use the PHI above.

_____

_____

Name the people and/or organizations (like relatives, for example) that you are authorizing to receive and use your PHI. (Ie: relatives, daughter)

_____

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