I understand that this authorization applies to all departments, health care providers and/or employees at CHC.

I understand that this authorization is voluntary.

I understand that once this information is disclosed to the Designated Person(s), it may be re-disclosed by them and may no longer be protected by state or federal privacy laws.

I UNDERSTAND THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR A NON-COMMUNICABLE DISEASE.

I understand the information authorized for verbal release may include drug/alcohol abuse treatment records. This category of medical information/records is protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below I specifically authorize any such records included in my health information to be released.

I understand that this authorization will be effective for my lifetime, unless revoked by me, and for one year following my death. I further understand that I may revoke this authorization at any time by sending a written statement of revocation to:

Community Health Connection, Inc.
Attn: Privacy Officer
2321 East 3rd Street
Tulsa, OK 74104.

If I revoke this authorization, it will not have any effect on any actions taken by CHC prior to the processing of the revocation.

My revocation will not apply to information already retained, used, or disclosed in response to this Authorization.

I understand that my refusal to sign this authorization will not negatively affect my health care services at CHC.

Signature of Patient, Parent, or Legal Representative*	Relationship to Patient	Date

*May be requested to show proof of representative status.

HIPAA Document - Retain for minimum of 6 years.