AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION ("PHI")

Patient Name:_____ Medical Record #:_____

Date of Birth:_____ Social Security #:_____

I hereby authorize the **Oklahoma State Department of Health ("OSDH")** to release the following information to:

_____;
Name and Address of School or Organization

and _____ .
Name and Address of Alternative School or Organization

Information to be shared:

Medical information relating to a positive confirmation of the novel coronavirus (SARS-CoV-2 or COVID-19) in the patient named above.

The information may be disclosed for the following purpose(s) only:

To notify the school that the patient attends in order for the school and OSDH to take measures that prevent the further spread of the coronavirus.

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of the PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect the eligibility for benefits, treatment, enrollment or payment of claims.
- The medical information may indicate that the patient has a communicable and/or non-communicable disease which may include, but is not limited to diseases such as the novel coronavirus, hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing the PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the Privacy Regulation.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following event:_____

_____

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Description of Legal Representative's Authority Expiration date (if longer than one year from date of signature or no event is indicated)